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ABSTRACT

The importance of science-based programs is now widely acknowledged in the substance abuse prevention field. The Center for Substance Abuse Prevention (CSAP) continues its efforts on several fronts to inform the field of the existence and availability of science-based program options. It primarily does this through its National Registry of Effective Prevention Programs (NREPP), which CSAP created to identify, review, and classify science-based prevention programs. NREPP rates science-based programs along a continuum of effectiveness, ranging from promising to model programs. This guide explains the NREPP review process and features the latest lists of CSAP-vetted science-based prevention programs. Model programs are the gold standard of the prevention field. They meet NREPP standards for effectiveness and have the added advantage of technical assistance from the program's developers. A user-friendly matrix, or chart, displays characteristics of the model programs and serves as a guide for practitioners. Summary descriptions about programs that have been designated as promising or effective through the NREPP process are also included in this publication. CSAP works with developers throughout the year to move these programs toward model status. This guide manifests CSAP's commitment to informing the field about the latest scientific information on substance abuse prevention. (GCP)

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2002 Conference Edition

A Practitioner's Guide to Science-Based Prevention

A Handbook of Promising, Effective, and Model Programs

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A Practitioner's Guide to Science-Based Prevention

A Handbook of Promising, Effective and Model Programs

April 2002

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Derived directly from the "Third Annual Report of the Center for Substance Abuse Prevention, Bringing Effective Prevention to Every Community: Update of Progress in Identifying Model Programs, Synthesizing Research, and Disseminating Knowledge," this Handbook presents prevention programs rated as scientifically defensible through CSAP's National Registry of Effective Prevention Programs (NREPP). Principal author of the document was Steven Schinke, Ph.D., of NCAP, in collaboration with Paul Brounstein, Ph.D., Division Director, and Stephen E. Gardner, D.S.W., Acting Deputy Division Director.

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Introduction

The importance of science-based programs is now widely acknowledged in the substance abuse prevention field. The Center for Substance Abuse Prevention (CSAP) continues its efforts on several fronts to inform the field of the existence and availability of science-based program options. It primarily does this through its National Registry of Effective Prevention Programs (NREPP), which CSAP created to identify, review, and classify science-based prevention programs.

NREPP rates science-based programs along a continuum of effectiveness, ranging from promising to model programs (see chart on page 3). This GUIDE TO SCIENCE-BASED PREVENTION explains the NREPPreview process and features the latest lists of CSAP-vetted science-based prevention programs.

Model programs are the gold standard of the prevention field. They meet NREPP standards for effectiveness and have the added advantage of technical assistance from the program's developers. A user-friendly matrix, or chart (beginning on page 67), displays characteristics of the model programs and serves as a guide for practitioners.

Also important are the programs that CSAP has deemed promising and effective. As is shown in the chart on page 3, promising and effective programs are science-based. Promising programs have shown some positive outcomes while effective programs consistently demonstrate positive outcomes and have been strongly implemented and evaluated. Model programs are simply effective programs that are available for dissemination and have technical assistance available. Summary descriptions about programs that have been designated as promising or effective through the NREPP process are also included in this publication. CSAPworks with developers throughout the year to move these programs toward model status.

The stressful times in which we live underscore the value of CSAP's commitment to find and disseminate best practices that are grounded in science. The emotional strain caused by the September 11 attacks and threats of bioterrorism have led increasing numbers of Americans to seek treatment for substance abuse problems. We know that exposure to trauma puts people at four to five times greater risk of substance abuse.

The National Registry of Effective Prevention Programs is expanding its scope to include prevention programs that address this and other new areas of concern, as described in this report. CSAP and its NREPP process will encourage practitioners and program developers to create innovative, rigorously evaluated programs on these issues for Registry review. Of particular interest are programs documented according to the guidelines laid out in CSAP's new manual on achieving outcomes ("Achieving Outcomes: A Practitioner's Guide to Effective Programs"), which describes the use of logic models and ongoing evaluation to document implementation and outcomes.

In all, this PRACTITIONER'S GUIDE TO SCIENCE-BASED PREVENTION manifests CSAP's commitment to informing the field about the latest scientific information on substance abuse prevention.

CSAP's MISSION

To decrease substance use and abuse by bringing effective prevention to every community.

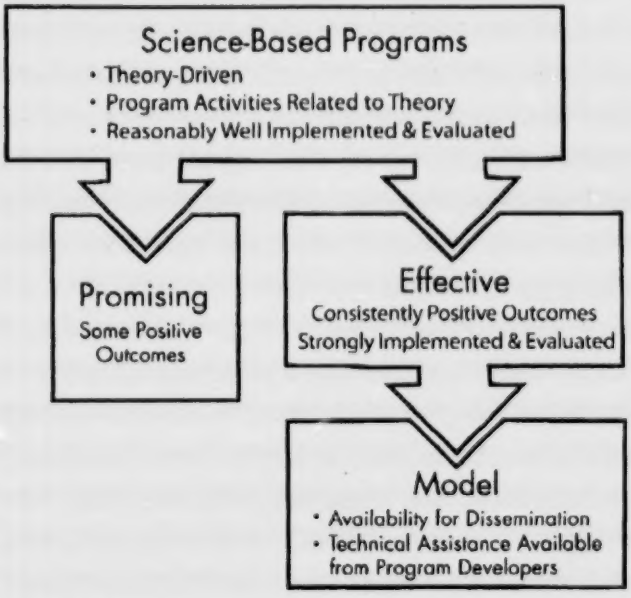
CSAP is one of three Centers in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS).

The NREPP Review Process

NREPP review initially focused on programs designed to prevent tobacco, alcohol, and illicit drug use problems among children and adolescents. Nearly 600 substance abuse prevention programs have been reviewed. To date, more than 40 of those programs have achieved the status of "promising." Another 40 are designated as "effective" while 31 more have been designated as "model." (It is important to note that model programs are effective programs that are available for dissemination and have technical assistance available through the developers). Suitable for implementation in many contexts—schools, families, communities, and the larger environment—these science-based programs offer practitioners options for choosing interventions, approaches, and curricula that address local needs.

Promising, Effective, and Model Programs

Definitions of the NREPP categories for promising, effective and model programs are detailed below.



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NREPP Review Process

NREPP identifies and reviews science-based prevention programs and classifies them as "promising," "effective," or "model" programs, as explained below. Published and unpublished program materials (e.g., grant and final reports, manuscripts under development) are submitted to NREPP and distributed to teams of scientists for review. Team members work independently to read, analyze, and score each program according to 15 criteria, summarized below. Review team members regularly meet to compare their assigned ratings, clarify any areas of disagreement, and undergo supervision for their program rating reliability. NREPP reviewers include doctoral-level scientists, experts in prevention research methodology and programs, and they prepare for their task through extensive training plus illustrative program reviews and critiques.

Review Criteria

- Theory – the degree to which programs reflect clear and well-articulated principles about substance abuse behavior and how it can be changed.
- Intervention fidelity – how the program ensures consistent delivery.
- Process evaluation measures – whether program implementation was measured.
- Sampling strategy and implementation – how well the program selected its participants and how well they received it.
- Attrition – whether the program retained participants during its evaluation.
- Missing data – how the developers addressed incomplete measurements.
- Outcome measures – the relevance and quality of evaluation measures.
- Data collection – the manner in which data were gathered.
- Analysis – the appropriateness and technical adequacy of data analyses.
- Other plausible threats to validity – the degree to which the evaluation considers other explanations for program effects.
- Replications – number of times the program has been used in the field.
- Dissemination capability – whether program materials are ready for implementation by others in the field.
- Cultural- and age-appropriateness – the degree to which the program addresses different ethnic/racial and age groups.
- Integrity – overall level of confidence that program findings are rigorous.
- Utility – overall usefulness of program findings to inform prevention theory and practice.

NREPP identifies and reviews science-based prevention programs and classifies them as "promising," "effective," or "model" programs.

Scoring Procedure and Definitions

Individual scores from members of each review team are compiled, together with their narrative descriptions of the review program's strengths, weaknesses, major components, and outcome findings. Summary scores from two parameters, Integrity and Utility, are then used to rank programs respectively on the scientific rigor of their evaluation and the practicality of their findings for substance abuse prevention.

Average scores among raters for those two criteria are then used to define programs in one of three categories: effective programs, promising programs, and programs with insufficient current support. Programs defined as effective have the option of becoming model programs if their developers choose to take part in CSAP dissemination efforts. The conditions for making that choice, together with definitions of the three major criteria, are detailed in the following paragraphs.

Effective programs are prevention programs that produce a consistent positive pattern of results. Only programs that positively affect the majority of intended recipients or targets are considered effective. These programs must score at least 4.0 on a 5-point scale on parameters of Integrity and Utility. Descriptions of all effective programs that have emerged from NREPP are provided in this Guide.

Model programs are effective programs whose developers have the capacity and have coordinated and agreed with CSAP to provide quality materials, training, and technical assistance to practitioners who wish to adopt their programs. That help is essential to ensure that the program is carefully implemented, and maximizes the probability for repeated effectiveness. This Guide includes descriptions of all model programs identified to date.

Promising programs provide useful, scientifically defensible information about what works in prevention, but do not yet have sufficient scientific support to meet standards set for effective/model programs. Nonetheless, promising programs are eligible to be elevated to effective/model status after review of additional documentation regarding program effectiveness. Promising programs must score at least 3.33 on the 5-point scale on parameters of Integrity and Utility. Originated from a range of settings and spanning many and diverse target populations, promising programs are rich sources of guidance for prevention practitioners and designers. Information on all promising programs from NREPP is available on our website, www.modelprograms.samhsa.gov.

Insufficient current support refers to programs that require additional data or details before they can receive a score warranting a level of effective or promising. Programs that score less than 3.33 on Integrity or Utility parameters – which are placed in the category of Insufficient Current Support – may be very worthwhile and have many implications to inform other prevention efforts. But, in their current form, these programs do not score sufficiently high to warrant a rating of promising or higher.

Nominating Programs for NREPP Review and Rating

Candidate programs for NREPP review come from four primary sources. The first source is the existing scientific literature. Research reports on prevention programs that have been published in scholarly journals provide many candidate programs. Recent years, in particular, have witnessed the publication of many successful prevention efforts – focused on tobacco, alcohol, and other drugs as well as on violence, HIV infection, and other behavioral and health risks. NREPP staff continually scan the corpus of scientific journals in which such papers appear and refer relevant ones for review. Unsurprisingly, scientific reports of prevention programs in the scholarly literature often substantiate outcome effects in a careful, compelling manner. Consequently, many effective programs that emerge from the NREPP process are supported by documentation in these scholarly papers.

Lists of effective programs as assessed by other rating processes provide a second source of candidate programs for NREPP review. Not only government agencies – e.g., National Institute on Drug Abuse, Centers for Disease Control and Prevention, Department of Education, Office of Juvenile Justice and Delinquency Prevention – but also nongovernmental bodies publish lists of programs that passed review through processes similar to NREPP. Though not usually employing the same criteria as NREPP, these other organizations nonetheless follow a rigorous process to screen and select prevention programs that have shown positive effects. From such listings, NREPPidentifies prevention programs for its own review. The NREPP process occurs independently of other reviews and is uninfluenced by prior findings – whether reported in scientific journal articles or by parallel review processes.

The third source of candidate programs for NREPP is CSAP. Using final reports submitted by its grantees, CSAP sends NREPPdescription and outcome information for the programs developed, tested, and implemented by those grantees. Final reports are written with great attention to detail about all facets of a prevention program and therefore usually contain all the information needed for a thorough NREPP review. When additional documentation is necessary, NREPP contacts the developers directly.

The fourth source of programs for NREPP consideration comprises general solicitations to the field. Responding to invitations from CSAP – posted on its website, mailed directly to agencies in the field, and announced at national conferences – program developers are encouraged to send to NREPP documentation of their successful prevention efforts. Programs developed in the field by practitioners who confront daily the challenges of substance abuse problems and myriad prevention issues are apt to reflect everyday realities in a manner not possible in academic or other removed settings.

Such field-based programs are strong candidates for NREPP and are the most desirable programs for subsequent dissemination. Though programs developed in the field often lack the outcome data that typify research-based programs, field programs offer great promise for responsively addressing contemporary substance abuse programs in real-world contexts. CSAP is therefore actively soliciting candidate programs.

Developers of candidate programs from the field might bear in mind that their program's chance for selection by NREPP is enhanced if they include outcomes documentation, including logic models and evaluation results, as outlined in "Achieving Outcomes: A Practitioner's Guide to Science-Based Prevention." As previously mentioned, the guide is one in a series of knowledge tools that marks CSAP's commitment to bring effective prevention to every community. The guide presents a logical framework and a practical process for demonstrating measurable prevention outcomes, including the following:

- Assessing needs, underlying conditions, and assets;
- Building organizational capacity;
- Selecting a best-fit science-based program;
- Implementing the program(s) using action plans and feedback; and
- Evaluating final program outcomes.

To access the guide, log on to www.preventiondss.org.

A SPECIAL INVITATION TO NOMINATE CANDIDATE PREVENTION PROGRAMS

Practitioners in the field are invited
to submit prevention programs for NREPP review.

Submission may occur through CSAP's Website,
http://model programs.samhsa.gov/nrepp.htm, or by mail to:

Steven Schinke
National Center for the Advancement of Prevention
Intersystems, 30 Wall Street, Fourth Floor
New York, NY 10005

To explore whether a program is a viable candidate
for review, contact Schinke directly toll-free
at (866) 43NREPP (436-7377),
toll-free fax (877) 413-1150,
or NREPP@intercom.com (E-mail).

New Areas for NREPP Review

In keeping with its current direction, CSAP is expanding the focus of NREPP reviews. Noted in the following paragraphs, this expansion encompasses our initial focus on programs aimed to prevent tobacco, alcohol, and other drug use problems among new populations. Further, we are interested in workplace programs, those aimed at HIV and AIDS, efforts to treat and prevent sequelae-associated post-traumatic stress disorder, and prevention and treatment programs for gambling disorders.

Substance Abuse Prevention with New Populations

NREPP continues to search for exemplary programs. Grassroots, community-based substance abuse prevention programs are particularly needed, especially those that serve populations underrepresented in the current NREPP database (e.g., programs for the elderly, those tailored expressly for ethnic-racial minority group members, and environmentally oriented programs). NREPP is also seeking new approaches to substance abuse prevention that are not only grounded in theory and science, but that also consider the real-world time, budgetary, and staffing constraints of program delivery in the field.

Workplace

By their nature, problems of substance use and abuse become exacerbated when they lead to impairments in everyday functioning. The workplace is the most frequent everyday setting in which those impairments are particularly costly. Individuals who use drugs and alcohol on the job, or who come to work under the influence, are a clear hazard to themselves, their co-workers, and their families. Workers in charge of sensitive operations, dangerous machinery, and various forms of transportation can cause inordinate damage if they are even slightly impaired by substance use. Just as substance use in the workplace requires special consideration, so do programs that address substance use among workers.

Consequently, programs to prevent and treat substance use in the workplace enjoy a long history in this country. To bring the best of those programs to the attention of the practice community, NREPP is now inviting and screening interventions, approaches, and curricula that address substance use and abuse in workplace settings. Those efforts take form as employee assistance programs, referral services, and programs to prevent not only substance use, but also interpersonal, traumatic, and family problems that are associated with substance use and that can lead to impairment within and outside of the workplace. NREPP has reviewed several workplace programs and found them of high quality. When their NREPP criteria scoring permit, these programs will be brought to the attention of field through CSAP's ongoing dissemination initiatives.

HIV and AIDS

Medical problems of HIV and AIDS have clear antecedents and correlates related to substance use and abuse. Not only are injected drugs a major conduit for HIV transmission, but persons under the influence of drugs and alcohol are more likely to take sexual risks that also are linked with exposure to HIV infection. Equally important, the prevention of HIV and AIDS are appropriate targets for NREPP inclusion given their serious consequence of the nation's public health.

In 2001, CSAP began subjecting HIV prevention programs to NREPP for review. Many of these programs were developed with funding from the Centers for Disease Control and Prevention and have undergone careful testing. Consequently, the NREPP review of HIV and AIDS prevention programs began with a body of existing research. From that research, one model program, two promising programs, and four effective programs emerged to join the NREPP database. Differing somewhat from prevention programs that heretofore have typified NREPP, the HIV programs target populations that are characterized by their demonstrated risk of exposure to HIV infection risk factors. Results of efforts to find HIV and AIDS prevention programs will be forthcoming this year.

Post Traumatic Stress Disorder (PTSD)

The terrorist attacks on the United States in September 2001, together with their aftermath and the subsequent retaliatory conflicts, have brought understandable attention to the manifestations, prevention, and treatment of psychological trauma, or post-traumatic stress. The disorder associated with post-traumatic stress, long documented among scientists and increasingly known among laypersons as PTSD, has clear salience for CSAP and our constituents. Not only are elevated rates of substance use linked with PTSD, but adults suffering from PTSD are at risk for a host of associated problems. In addition, spouses and other family members of adults experiencing PTSD show increased rates of drug and other substance use, as well as other psychosocial and health problems.

Children who have undergone trauma are of special interest to CSAP. Relative to adults, young people have less sophisticated coping mechanisms and lack the life experience to place horrific events in any historical context or perspective. Children and adolescents are, however, ideal candidates for prevention programs. Unlike their adult counterparts, youth are denied easy access to harmful substances and are unaccustomed to self-medicating with substances as a way to reduce stress and other post-traumatic effects. PTSD intervention programs with young people, therefore, can concurrently address the direct effects and consequences of the trauma.

For these reasons, the National Registry of Effective Prevention Programs is now including PTSD intervention programs in its screening and review process. To date, several PTSD programs have been subjected to NREPP's 15 rating criteria—modified as appropriate to fit the parameters of PTSD and its manifestations. As

programs are discovered and ranked as promising and model, they will be entered into CSAP's Decision Support System along with all other NREPP products.

Gambling

Gambling is another disorder that has caught the attention of CSAP and NREPP over the past year. With clear implications for problems of addiction and substance use, gambling is also a problem in its own right. Gambling is increasingly recognized as a serious threat to not only the economic well-being of those who frequently engage in it for high stakes, but also as a factor contributing to damaged interpersonal relationships, job loss, and family problems. Though in its nascence, the serious scientific study of gambling has already yielded answers to many questions with salience for prevention programming. Scientists know, for instance, that chronic gambling is linked with many of the same risk and protective factors commonly understood to affect substance use. Indeed, recent data indicate that U.S. adults who have a current dependency on alcohol are 23 times more likely to have a current gambling problem than those who did not drink.

Still, the epidemiology of gambling differs from alcohol and drug abuse. For example, gambling is more common among people from lower socioeconomic groups, as well as among Black and Hispanic people, than it is among affluent persons and non-minority group members. The incidence of current gambling pathology is seven to eight times as high among Black and Hispanic men and women compared with White men and women. Data on problem gambling appear to show a disquieting trend. A 1998 nationwide survey conducted for the National Gambling Impact Study Commission found that the national rate of pathological gambling was a little less than 1%. Recent data find the rate of Americans who were currently pathological gamblers at between 1% and 2%. About 5% of Americans are judged to currently be problem gamblers. The lifetime prevalence of problem gambling is estimated to be from 4.8% to 11.5%. Overall, more than 80% of men and women reported gambling in the past year.

Unsurprisingly, gambling also appears to share with substance abuse opportunities for intervention and prevention. The emerging science of gambling, however, is just beginning to focus on the development and testing of programs suitable for field implementation. In its ongoing mission to codify science-based prevention programs, NREPP has taken an initial look at the available research on programs aimed at reducing the risks of habitual gambling.

Promising Program Descriptions

Promising programs are those that have been reasonably well evaluated, but the findings are not yet consistent enough, or the evaluation not yet rigorous enough, for the program to qualify as an effective program. They may provide useful and scientifically defensible information about what works in prevention, but they do not yet have sufficient scientific support to meet CSAP standards as effective/model programs. These promising programs are rich sources of information for prevention practitioners and designers and may move into effective, or even model, status through additional refinement and evaluation. On the following pages you will find brief descriptions and contact information for the following promising programs:

Adolescent Alcohol Prevention Trial

AIDS/Drug Injection Prevention Program

Asian Youth Alliance (AYA)

Baby Safe Hawaii

Be A Star

Behavioral Monitoring and Reinforcement Program (BMRP)

Big Brothers-Big Sisters of America

Bilingual/Bicultural Counseling and Support Services

Club Hero

Colorado Youth Leadership Project (CYLP)

Faith-Based Prevention

Family Health Promotion Program (FHPP)

Focus on Families (FOF)

Gatekeeper Case Finding & Response System

Get Real about Violence

I Can Problem Solve (ICPS)

Kids Intervention with Kids in School (KIKS)

Linking the Interests of Families and Teachers (LIFT)

Massachusetts Tobacco Control Program

Multimodel Substance-Abuse Prevention

New Connections: Infant Intervention Program

Parent-Child Assistance Program (P-CAP)

Parenting Partnership

Peer Assistance and Leadership (PAL)

Perinatal Care Program

Plan a Safe Strategy (PASS) Program

Project BASIS

Project Break Away

Project Link

Project PACE

Sembrando Salud

SISTERS

Storytelling for Empowerment

Strengthening Hawaii Families (SHF)

Strengthening the Bonds of Chicano Youth and Families

Teams-Games-Tournaments Alcohol Prevention

Teenage Health Teaching Modules

Tinkham Alternative High School

Urban Women Against Substance Abuse (UWASA)

Woodrock Youth Development Program

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Adolescent Alcohol Prevention Trial*

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Web site: www.tanglewood.net

The Adolescent Alcohol Prevention Trial (AAPT) is a classroom-based drug prevention program administered in the fifth grade with booster sessions conducted in the seventh grade. AAPT utilizes two social psychology-based strategies for preventing the onset of adolescent drug use. The first strategy, Resistance Training, is designed to give adolescents the behavioral skills necessary to refuse explicit drug offers. The second strategy, Normative Education (NORM), is designed to correct erroneous perceptions about the prevalence and acceptability of adolescent substance use and to establish conservative group norms. In addition, the program includes instruction about the social and health consequences of adolescent drug use. In research testing, the combination of resistance skills training and normative education prevented drug use, but resistance skills training alone did not.

*Adolescent Alcohol Prevention Trial was a research project. The resulting curriculum is the model program All Stars™.

AIDS/Drug Injection Prevention Program

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This prevention program is based on social learning principles. The intervention is delivered in four one- to two-hour sessions over a two-week time period, led by two trainers who encourage a therapeutic atmosphere in which participants feel free to discuss personal problem situations and seek help from the trainers and from their peers. Avoiding injection of illicit drugs is the program's primary goal; reduction in non-injected use of illicit drugs is a secondary goal. Emphasis is placed on recognizing and admitting problems with illicit drug use and not making those problems worse by injecting drugs. This is a community-based intervention for adults who are illicit drug injectors and intranasal ("sniffer") heroin users who are at high risk of injecting drugs. Four sessions cover understanding AIDS, risks of drug use and drug injection, sexual behavior and AIDS, and seeking entry into drug abuse treatment programs. Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.

Asian Youth Alliance (AYA)

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Asian American Recovery Services
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Daly City, CA 94014
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Web site: www.aars-inc.org/aya

The Asian Youth Alliance Program (AYA) is a multilevel, ethnic-specific prevention program developed by Asian American Recovery Services in Daly City, California. The long-term goals of decreasing high risk behaviors and substance use among Filipino and Chinese youth, ages 15-20 and 15-18 respectively, living in Daly City are accomplished by successfully altering intermediary knowledge, attitudinal, and skill deficits. The AYA Program achieves these goals by building a consortium of Asian-focused youth-serving agencies to better meet the needs of targeted ethnic groups, particularly in specific Asian communities, through curriculum-based prevention interventions. The program can be implemented in urban and suburban settings. Collaboration among community-based agencies is the cornerstone of program success. While the program was successful in decreasing intermediary risk (tolerance for drugs, social anxiety) and increasing intermediary protective (cultural pride) factors, further evaluations of the program are needed to determine if changes in these variables will produce anticipated changes in related high-risk behaviors and substance abuse outcomes.

Baby SAFE (Substance Abuse Free Environment) Hawaii

Barbara Yamashite
Hawaii State Department of Health
741-A Sunset Avenue
Honolulu, HI 96816
Phone: (808) 733-9022
Fax: (808) 733-9032

The Baby SAFE (Substance Abuse Free Environment) Hawaii Program was established by the Hawaii State Department of Health in 1990, creating a State Council on Chemical Dependency and Pregnancy and five specialized committees. The goals of the program are to (a) increase the availability and accessibility of prevention, early intervention, and treatment services for pregnant and postpartum women in Hawaii; (b) decrease the incidence and prevalence of drug and alcohol use among pregnant and postpartum women in Hawaii; and (c) improve birth outcomes for women who use alcohol, tobacco, and other drugs during pregnancy, and decrease the number of infants affected by maternal substance use. The program, which is service intensive, can be implemented at drug treatment sites, health clinics, or other agencies.

Be a Star

Rev. Gene Bartell
Board for Innercity Missions
5621 Delmar, Suite 104
St. Louis, MO 63112
Phone: (314) 383-1733
Fax: (314) 361-6873

Be a Star was developed to serve African-American children between the ages of 5 and 12 living in St. Louis, and to build on the afterschool activities already in place at the United Church Neighborhood Houses (UCNH). The neighborhoods served by the UCNH include areas where gang activity is high, where children experience high rates of abuse and neglect, where proportionately large numbers of families receive AFDC, and where the high school dropout rate is 52 percent. The agency has responded to community needs by developing afterschool programs for neighborhood youths and providing a day camp during the summer. In addition, the agency works closely with community residents to place greater emphasis on a safe environment for children and works with other community agencies to coordinate the minimal services available to neighborhood residents. The program can be administered in neighborhood community centers.

Behavioral Monitoring and Reinforcement Program (BMRP)

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The Behavioral Monitoring and Reinforcement Program (BMRP) is a school-based early intervention program that focuses on behavior modification and reinforcement of academic performance and obeying school rules. The BMRP aims to improve student attendance, promptness, and grades, and to decrease discipline referrals. BMRP focuses on seventh grade students who have exhibited at least two of the following predictive characteristics: (a) low academic motivation, (b) a feeling of distance from the family, and/or (c) discipline referrals. It is designed to be implemented over a two-year period and include weekly teacher consultations, weekly student group meetings, and periodic contact with the parents. A third year of less frequent booster sessions is also recommended. The program can be implemented in both urban and suburban school systems. Program outcomes at one-year and five-year followup showed significant differences between the intervention and control groups in extent of serious school-based problems, reported abuse of drugs, reported criminal behavior, and numbers of arrests.

Big Brothers-Big Sisters of America

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Big Brothers-Big Sisters of America (BBBSA) is a mentoring program that matches an adult volunteer to a child, with the expectation that a caring and supportive relationship will develop. Equally important is the ongoing supervision and monitoring by a professional staff member, who selects, matches, monitors, and closes the relationship with the volunteer and child. The foremost goal is to develop a mutually satisfying relationship through community and site-based activities. More specific goals might relate to school attendance, academic performance, relationships with other children and siblings, general hygiene, learning new skills, or developing a hobby. BBBS typically focuses on youth aged 6 to 18 years. BBBS agencies operate in a variety of settings, ranging from urban to rural. Evaluation reveals that treatment youth were better than control youth in academic behavior, attitudes, and performance; had higher quality relationships with their peers and with their parents or guardians than control youth; and were less likely to initiate drug or alcohol use.

Bilingual/Bicultural Counseling and Support Services (formerly Proyecto CHAC)

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Bilingual/Bicultural Counseling and Support Services works with the large Hispanic/Latino population of Mountain View, many of whom have few opportunities to assimilate into the mainstream community, leading to alienation and isolation. Strategies include: counseling and education programs; information and referral services to low-income families; individual and group activities for at-risk youth; child abuse, domestic violence and rape intervention and prevention services; Latino women's support group, parent education groups, and more. There are also a number of program strategies based in the schools and in the afterschool Tween-Time Mountain View Recreation program, gang prevention groups, and parent education and support groups. Some 75 percent of all Latino youth who received the services were better acculturated, had greater confidence, and appeared to feel more part of their school community.

Club Hero

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Club Hero is an afterschool prevention program sponsored by National Families in Action of Atlanta, Georgia. It features a drug education curriculum that teaches children how the brain works and how drugs change the brain, change behavior, and produce addiction. Parental involvement is also an integral part of the program. Club Hero is conceptually grounded in literature demonstrating the link between the family environment and an adolescent's decision to use alcohol, tobacco, and other drugs; and evidence supporting the efficacy of prevention programs employing social influence and generic skills training models. The program focuses on African-American sixth-grade students attending public middle school who qualify for free or partially subsidized breakfasts and lunches. Club Hero can be implemented in any middle school setting. The program has been successfully replicated in 17 mostly rural and suburban communities. Evaluations reveal significant increases in students' knowledge of alcohol, tobacco, and other drug use and its impact on African-American families and communities and increased family bonding.

Colorado Youth Leadership Project (CYLP)

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The Colorado Youth Leadership Project (CYLP) was developed to address identifiable drug risk factors through school-based program components for at-risk seventh graders in middle school. The project was designed to (1) reduce factors in the individual, peer group, and school that place students at high risk for using alcohol, tobacco, and other drugs, and (2) increase the resiliency/protective factors within students and peer groups so there is a reduction in the likelihood that students will use alcohol, tobacco, and other drugs. The intervention includes six major components that are designed to help high-risk youth become more resilient and avoid using alcohol, tobacco, and other drugs. There is also a summer leadership program. Project ALERT Curriculum and the Second Step Violence Prevention Curriculum, both nationally validated curricula, are used in the Life Skills component of CYLP.

Faith-Based Prevention

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The Health Advisory Council developed the Jackson County Alcohol and Other Drug Prevention Partnership Concept. The group consists of six African-American churches that successfully implemented health promotion projects funded by the Department of Health and Human Services, Office of Minority Health, American Heart Association, and the Florida Department of Health and Rehabilitative Services. The founding group then recruited other minority organizations and majority providers of drug, health, and educational services to participate. The partnership has existed for several years and is ongoing. Evaluations reveal significant accomplishments that include: a coordinated approach to prevention planning in a rural area with organizations utilizing the locality development approach; behavioral lifestyle changes via the church prevention programs, stressing the target populations' culture and value systems that reinforced school activities; and "Old South" cultural practices that allowed the African-American community to improve the quality of life for all Jackson County residents.

Family Health Promotion Program (FHPP)

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CODAC developed the Family Health Promotion Program (FHPP) to begin addressing the many needs of the people living in the targeted area. FHPP is a primary prevention program for a traditionally hard-to-reach and under-served population of predominantly Hispanic/Latino origin. Most family members are monolingual Spanish speakers. The program focuses on children three to eight and their families. Through its home visitation program, the resiliency skills and protective factor curriculum being taught in the Connie Chambers Early Childhood Education Center is explained and adapted for home use. Families are provided opportunities to participate in enjoyable school activities, thus promoting school bonding. Children are involved in developmentally appropriate activities in childcare, school, and recreational activities to develop resiliency skills. Parents are involved in activities that empower them and increase protective factors. FHPP can be implemented in school and community settings. It utilizes the Building Me activities manual. A quasi-experimental, pre-test/post-test showed that as a rule the Latino children in the CODAC programs improved dramatically from pre-test to post-test. On many measures they improved substantially more than the comparison group children.

Focus on Families (FOF)

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Focus on Families (FOF) combines parent skills training and home-based case management services to reduce parent's risk for relapse and children's risk for substance use while enhancing protection. The intervention aims to improve opiate-addicted parenting and relapse skills through systematic group training that follows a structured curriculum format. Focus on Families includes a parenting curriculum, taught by a professional team, where parents are taught different skills and provided with home practice activities during each session. The program also includes home-based case management to help parents and children generalize and maintain skills learned in the group sessions and assess clients'appropriate use of skills. The intervention is suitable for a clinic-based setting. Following the FOF intervention of nine months, experimental parents received higher scores on the problem-solving skills and drug-related situations, used significantly less heroin at the end of parent training and at the 12-month followup, and used significantly less cocaine at the 12-month followup.

Gatekeeper Case Finding and Response System

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Gatekeeper was developed by the late Raymond Raschko, M.S.W., at Elder Services, Spokane Mental Health, Spokane, Washington, in 1978. It was designed to identify at-risk older adults who do not typically come to the attention of the mental health and aging service delivery systems. With this technique, nontraditional community referral sources, such as employees of community businesses, and other community organizations, are organized and trained to identify high-risk elders who may be experiencing problems that threaten their ability to live independently and safely in the community. Gatekeepers include meter readers, utility workers, property appraisers, bank personnel, postal carriers, police, sheriff and fire department personnel, and others who, through their normal daily routine, come into contact with the most isolated community-dwelling older adults. Gatekeepers refer the older person in need to a designated agency for a comprehensive assessment and subsequent linkage to mental health, aging, medical, or other social services. The model has been adapted successfully in urban, rural, and suburban communities and coordinated by single service systems or in collaboration with multiple systems.

Get Real About Violence

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Get Real About Violence (GRAV) is a K-12, research-based prevention program that addresses a wide range of violent behavior in students—from bullying and verbal aggression at early grades, through fighting and social exclusion at middle grades, to relationship abuse and assaults in later grades. GRAV places emphasis on enlisting the support of bystanders, changing violent norms, teaching social skills, and building communication and partnerships between adults and youth to stop violence. It is suitable for all school-based settings and most community-based learning situations. The curriculum, for students in grades K-3, 4-6, 6-9, and for school staff in K-12 schools, teaches students special skills to stay safe and healthy by showing them how to maintain self-control when tempted by violence, resolve conflicts without violence, and prevent or avoid violent situations.

I Can Problem Solve (ICPS)

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I Can Problem Solve (ICPS) is a training program that is both preventive and rehabilitative. ICPS helps children to resolve interpersonal problems and prevent antisocial behaviors by teaching them how to think, not what to think. The ICPS training teaches the problem-solving skills of perspective-taking, recognition of people's potential motivations for behavior, sensitivity to the existence and causes of an interpersonal problem, and listening and awareness skills. These skills enrich children's ability to generate alternative solutions to real-life problems, anticipate potential consequences to an act, and plan sequenced steps to a stated interpersonal goal. ICPS also trains teachers to engage in a problem-solving style of communication (called ICPS dialoguing) when actual problems arise. Instead of telling, suggesting, or even explaining why a child should or should not do something, teachers ask questions to define the problem and guide consequential thinking and thinking about the child's own and others' feelings. This approach gives children the skills and freedom to think and solve problems for themselves. Based on measures of the intervention with kindergarten children in the fall and the following spring, 83 percent of the trained kindergarten children were rated as adjusted when compared to 30 percent of the controls in the spring.

Kids Intervention with Kids in School (KIKS)

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Kids Intervention with Kids in School (KIKS), is a school-based youth development and primary prevention program for children in grades 6 to 12, administered by the Children's Home Society of New Jersey (CHS), a private, not-for-profit, statewide agency. The goal of the KIKS program is to help pre-adolescent and young adolescent students avoid self-destructive behaviors and cope in positive ways with personal and social problems they encounter in their everyday lives. The KIKS program has five major components: youth development groups, afterschool activities, tutorial program, parent involvement, and summer peer leader training. Children in grades 6 to 8 meet weekly during the school year in groups of up to 15, led by teenage peer leaders from grades 8 to 12 who are supervised by adult group workers. The teen and adult leaders use experiential activities to motivate the younger children to adopt, and value, self-preserving behaviors and to stay in school and learn. They participate in group discussions, role-playing, and other hands-on activities to learn and practice how best to cope with problems at home, in school, or in their social interactions with peers.

Linking the Interests of Families and Teachers (LIFT)

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Linking the Interests of Families and Teachers (LIFT) is a research-based intervention program designed to prevent the development of aggressive and antisocial behavior in children within the elementary school setting. LIFT has three main components: (1) child social skills training, (2) the playground Good Behavior Game, and (3) parent management training. Child social skills training sessions, held during the regular school day, include 20, one-hour sessions over a 10-week period in two distinct segments. Session content focuses on positive reinforcement, discipline, monitoring, problem solving, and parent involvement in the school. LIFT has been found to decrease child physical aggression toward classmates on the playground, to increase teacher positive impressions of child social skills with classmates, and to decrease parent aversive behavior during family problem-solving discussions.

Massachusetts Tobacco Control Program

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The Massachusetts Tobacco Control Program (MTCP) is one of the Nation's most comprehensive programs to combat tobacco use. MTCP fosters youth prevention efforts in three broad categories: (1) community efforts to increase enforcement of youth-access provisions, including banning free samples, requiring permits for tobacco retailers, restricting access to vending machines or banning them entirely, staging buy attempts by minors, and funding community-based tobacco prevention programs; (2) school efforts to inform youth of the harmful effects of smoking and to involve them in positive efforts to prevent smoking; (3) media efforts, including enlisting celebrities in antismoking public relations efforts and implementing statewide media campaigns aimed at reducing smoking and smokeless tobacco use. The program is suitable for implementation in urban school systems.

Multimodel Substance Abuse Prevention

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The Multimodel Substance Abuse Prevention project was implemented at a residential treatment center for court adjudicated males aged 13 to 18. All of the youth were subject to multiple risk factors in the individual, school, peer, and neighborhood domains. The main purposes of the project were: (1) to determine the effectiveness for reducing substance use/and illegal behavior of each of two intervention programs: (a) a triple module skills training classroom program, consisting of Botvin's Life Skills Training, Prothrow-Stith's Anti Violence Program, and Raths Values Clarification procedure; and (b) a program consisting of a group role-play procedure and family therapy sessions; and (2) to compare the degree of effectiveness of Group A participants, who were provided with the multimodel classroom training, with the effectiveness of Group B, who were provided with the classroom program plus the group role-play and family therapy components. The participants in Group A and B combined reported significantly greater reduction at followup than the controls (Group C) in drug use, in the perpetration of illegal offenses, and in the selling of drugs.

New Connections: Infant Intervention Program

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New Connections is a family-focused intervention that serves substance-exposed children ages 0 to 6 and their parents. By enhancing protective factors and reducing known risk factors, the program aims to decrease levels of developmental delay and impairment in children; increase levels of child and caregiver attachment and bonding; decrease maternal depression; improve parenting and family management skills; and increase access to and use of health and community support services. New Connections maintains positive working relationships with many community partners to provide integrated services for substance-exposed infants and children; parent education classes; and parent recovery support services. In evaluating New Connections, significant results were reported in knowledge regarding child health and development and in decreased maternal depression and parenting stress.

Parent-Child Assistance Program (P-CAP)

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The Parent-Child Assistance Program (P-CAP) is a paraprofessional home visitation model for extremely high-risk substance abusing women. The program uses a case-management approach to achieve four goals: (1) to assist mothers in obtaining treatment, maintaining recovery, and resolving the complex problems associated with their substance abuse; (2) to guarantee that the children are in a safe environment and receiving appropriate health care; (3) to link families with community resources; (4) to demonstrate successful strategies for working with this population in order to prevent the risk of future drug- and alcohol-affected children. Paraprofessional advocates have a maximum caseload of 15 families. They visit client homes, transport clients and their children to important appointments, link clients with appropriate service providers, work actively within the context of the extended family, trace clients who are missing, and provide advocacy services for the target child, regardless of who has custody of the child. Clinical supervisors meet individually with advocates on a weekly basis to review cases. The intervention lasts 36 months. Advocates visit client homes weekly for the first six weeks, then biweekly or more frequently, depending on client needs.

Parenting Partnership

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Parenting Partnership is a collaborative initiative between corporate worksites and human service providers that focuses on enhancing parenting skills, knowledge, and attitudes, while facilitating the creation of support networks within the worksite. To address systemic barriers to program participation by working parents, the Parenting Partnership delivers training sessions in partnership with corporations at the worksite. Parent training courses are led by a trained facilitator and held in the worksite during the employee's lunch/meal time. Each complete Parenting Partnership course provides 24 one-hour sessions, twice a week, for 12 weeks. Program dosage is significantly related to impact: parents in the program who received high dosage levels (i.e., more than 80% of sessions) showed both better short-term and longer-term impacts across 18-month followups on child behavior problems and strengths, substance abuse resistance related knowledge and attitudes, reduced parental stress, depression and irritability, and increased utilization of social support.

Peer Assistance and Leadership (PAL®)

(formerly Peer Assistance and Leadership Program Services)

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The Peer Assistance and Leadership (PAL®) program is a nationally recognized program operating in 350 Texas school districts and in five other states. Long-term objectives are reduction of use and abuse of alcohol, tobacco, and illicit drugs. Short-term objectives include improvements in school attendance and grades, reduction of discipline referrals, increased performance on standardized tests, improved attitude toward school, and improved behavior at home. The PAL curriculum was initially developed for high school students, but now includes middle school and elementary school students. An independent evaluation during the 1996-97 school year showed increases in grade point averages and percentage of students passing Texas Assessment of Academic Skills and decreases in student absences and student disciplinary referrals following program participation.

Perinatal Care Program

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The Perinatal Care Program was designed to facilitate intervention and prevention strategies for drug and alcohol abusing women who had prematurely delivered cocaine exposed babies. Most of these mothers were single, on public assistance, and had not completed high school. They lived in inner city neighborhoods characterized by disproportionate rates of violence, poverty, poor health care access, and organized drug activity. The Perinatal Care Program offers the following assistance: ambulatory pediatric care; child developmental assessments and referrals; family case management; physical therapy for hospitalized premature infants and caregiver education on the use of therapeutic techniques; parent education classes; caregiver-infant development interventions; caregiver support groups; transportation to all scheduled program activities; linkage referral services for substance abuse treatment, daycare, vocational training and other social services.

Plan A Safe Strategy (PASS) Program

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The Plan A Safe Strategy (PASS) Program is an education program of 12 lessons designed to weaken students'intentions to drink and drive or to be the passenger of a driver who has been drinking. PASS is also designed to strengthen the participant's intentions to use alternative strategies and to pre-plan in order to avoid these situations. The program proceeds on the assumption that the intention to perform or not perform an act is the strongest predictor of future action. The outcome goal for the target population of tenth-grade students in rural and urban areas of Queensland, Australia, is to reduce students'later involvement in drinking and driving related situations. Results of the short-term evaluation (1988) revealed strong trends in the desired direction in reduced drinking and driving and passenger behaviors. Attitudes towards drinking and driving and being a passenger in drinking and driving situations and myths about safety in these situations changed significantly in the desired direction. Students from the intervention group were also significantly more likely to be prepared to use alternatives in target situations and to avoid these situations.

Project BASIS

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Project BASIS is a school-based program designed to address the following components: (1) increasing the clarity of school rules and consistency of rule enforcement, (2) improving classroom organization and management, (3) increasing the frequency of school/parent communications regarding student behavior, and (4) replacing punitive disciplinary strategies with positive reinforcement of appropriate behavior. The BASIS program advocates the adoption of a schoolwide computerized behavior tracking system. The computer system also facilitates improved school/parent communication by generating letters regarding both positive and negative student behavior. Positive reinforcement strategies replace punitive disciplinary strategies schoolwide. Teachers are trained in this new system and also classroom organization and management.

Project Break Away

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Several studies have demonstrated the effectiveness of long-term, afterschool programs that combine remedial/compensatory education programs, recreational opportunities, nutritional supplementation, along with social and life skills training, and education about substance use and other health issues. Project Break Away provided an afterschool and summer educational and recreational substance use prevention program for adolescents who were exclusively on supervised probation through the Monroe Circuit Court. Specifically, the target population was middle school-aged youth between the ages of 12 and 14 years on probation, determined to have a history of early involvement or being at high risk of involvement with substance use, in need of adult supervision after school hours, and at risk of dropping out of school or who do not attend school. Participation in the project was one of several options the adolescents could choose as part of their probation order. The intervention is suitable for other school- and community-based settings. The programming was provided for each participant, three days a week during the school year and for eight weeks during the summer. Resources included the "Making Decisions" curriculum. Major program outcomes showed that a comparison group indicated a greater increase in cigarette use than both low dosage and high dosage intervention groups. Project Break Away participants who received low dosage reported significantly less heroin/opium use compared to comparison group members and participants who received high dosage.

Project Link

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Project Link is a hospital-based program sponsored by Women and Infants Hospital of Providence, Rhode Island. It features clinical and case management services, individualized to the needs of enrolled clients, that focus on substance abuse treatment, crisis intervention, and counseling. Project Link's mission is to integrate specialized substance abuse services into the maternal-child health system at Women and Infants Hospital. The program serves pregnant and postpartum women with substance abuse problems that deliver at Women and Infants Hospital. The women reside in an economically disadvantaged, urban community with high drug trafficking. Project Link can be implemented in other hospital-based settings. Project Link is a multicomponent program. Clinical services include: substance abuse assessment, crisis intervention, comprehensive psychosocial assessment, individual therapy, group therapy, child and family therapy, toxicology screening, and referral to ancillary services. Case management services include: home visiting, parenting assessment, parenting education, monitoring of pediatric visits, HIV education, and GED/literacy tutoring..

Project PACE

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The objective of Project PACE (Participation and Cooperation in Education), a primarily school-based, high-impact, prevention/education program, was to enable the Town of Huntington Youth Bureau to replicate a model high-risk youth program for the prevention of alcohol, tobacco, and illicit drug use. Project PACE focused on the prevention of substance use by providing a series of intensive interventions to fourth grade students (determined to be at risk) and their families in Huntington Intermediate and Southdown Intermediate schools. These interventions were meant to strengthen protective factors and reduce risk factors in three domains: the individual at-risk youth, the family, and the school. The intervention is suitable for other school-based settings. The program had a positive impact on reducing school absences. The low risk participants showed increased self-esteem while the high-risk participants and the control group showed a reduction in self-esteem. There was a general decrease in negative problem behaviors for the participant group and the high-risk control group in the pre- and post-test period, while the low risk control group experienced an increase in negative behaviors.

Sembrando Salud

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Sembrando Salud is a culturally sensitive tobacco and alcohol use prevention program specifically adapted for migrant Hispanic youth and their families. The program is designed to improve parent-child communication skills as a way of improving and maintaining healthy youth decisionmaking. Sembrando Salud contains a school and family curriculum delivered by bilingual/bicultural college students. Through presentation of information, modeling, and behavioral rehearsal, adolescents are exposed to how problems can be identified and analyzed, solutions generated, decisions made and implemented, and evaluated. Another component of this program is the specific focus on developing parental support for the healthy decisions and behaviors of the adolescents through enhanced parent-child communication. The program targeted adolescents between the ages of 11 and 16 and their families, identified through the Migrant Education Program in San Diego County. The intervention is suitable for other school-based settings.

SISTERS

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SISTERS Intervention Services is a comprehensive paraprofessional case management program for substance abusing pregnant and postpartum women receiving detoxification treatment services. The program provides peer support and case management to ensure the coordination of drug treatment, prenatal, postpartum, pediatric, and family support services for pregnant and postpartum women. The SISTERS program was specifically designed to add peer-oriented outreach and case management to the existing Maternal Substance Abuse Services Program. The SISTERS program served pregnant women, of which the majority were either African American or Hispanic/Latino. The intervention is appropriate for service provider environments, which address women's health issues, particularly pregnancy, substance abuse, and trauma. The project demonstrates the effectiveness of peer counseling. A repeated-measures (intake, two months, six months) evaluation design with a comparison group of non-SISTERS clients from the clinic reported significant positive outcomes.

Storytelling for Empowerment

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The Storytelling for Empowerment Project is a school-based secondary prevention, designed for club and classroom settings, serving American Indian and Latino-Latina middle school youth. The specific target populations are American Indian middle school-aged youth living on a rural Indian Nation and Latino-Latina middle school-aged youth living in urban settings. The intervention is suitable for club formats and other school-based settings. The project addresses the risk factors of confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. The goal of this program is to decrease the incidence of ATOD use among high-risk youth by identifying and reducing factors in the individual, family, school, peer group, neighborhood/community, and society/media that place youth at high risk for substance use. In addition, it attempts to enhance factors that may strengthen youth resiliency and protect them from substance use. The major components of the Storytelling for Empowerment Project are the Storytelling PowerBook, which is a 27-lesson activity book, accompanied by a detailed Facilitator's Guide. The intervention can be implemented within three months during the school year.

Strengthening Hawaii Families (SHF)

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Strengthening Hawaii Families (SHF) is a culturally relevant, family-focused prevention program designed by the Coalition for a Drug-Free Hawaii (CDFH). The program targets Pacific Island and Asian youth, specifically children in grades three to five enrolled in elementary schools on the island of Oahu, Hawaii, and their parents. SHF can be implemented in other urban, suburban, and rural school and community-based settings. SHF prevents substance abuse and related problems by improving family relationships and functioning, parenting skills, and children's social skills, and by reducing behavioral problems among children. The prevention intervention is based on evidence demonstrating the link between poor family functioning and alcohol, tobacco, and other drug use, as well as literature delineating risk and protective factors unique to Pacific Island and Asian families with elementary school-aged children. The SHF model provides the tools and process to build on existing strengths through clarification of family and cultural values, family skills building, and nurturing connections among families, schools, and their communities. A standardized curriculum delivers program content to groups of 6 to 10 families attending weekly two-hour meetings. Through guided discussions, hands-on activities, and group sharing,

Strengthening the Bonds of Chicano Youth and Families

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Strengthening the Bonds of Chicano Youth and Families (El Proyecto de Nuestra Juventud) is a community-based, culturally appropriate intervention model for rural Hispanic youth in Central Arizona. The project recruited youth from the target areas of the City of Eloy and the neighboring community of Picacho, both rural agricultural areas. Participants had certain risk factors, including siblings of substance users, children of substance users, juvenile delinquents, children at risk of becoming teen parents, children at risk of dropping out of school, and children residing in public housing. The project was conceived and implemented by the Pinal Hispanic Council, a minority, nonprofit organization based in the City of Eloy. The intervention is suitable for a community-based setting. The comprehensive, multilevel program is rooted in a family-oriented approach that is based on Mexican-American culture, values, and principles.

Teams-Games-Tournaments Alcohol Prevention (formerly Teams-Games-Tournaments)

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The Teams-Games-Tournaments (TGT) Alcohol Prevention program combines peer support with group reward structures as the approach to alcohol prevention. The TGT focuses on group, rather than individual, achievement to learn about alcohol and its effects, including biological, psychological, sociocultural, and physiologic determinants and attributes of alcohol; self-management skills for responsible drinking; drinking and driving; recognizing and treating drinking problems; and assertiveness training to respond to peer pressure regarding alcohol. The program served high school sophomores, juniors, and seniors, and included metropolitan, semi-metropolitan, and rural areas. In all participating schools, students received instruction by one of three methods: the experimental TGT method, traditional instruction (one week course material developed by the State Department of Education and taught by regular school teachers or the highway patrol), or no instruction (the control group).

Teenage Health Teaching Modules

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Teenage Health Teaching Modules (THTM) is a comprehensive, secondary school health education curriculum developed by Education Development Center of Newton, Massachusetts, for middle and senior high school students in grades 6 through 12. The program is intended to positively affect student health knowledge, attitudes, practices, and self-reported behaviors. Unlike traditional health instruction, THTM materials are organized according to developmentally based tasks of concern to adolescents, rather than by content areas. All modules are intended to build the following seven skills: self-assessment, risk assessment, communication, decisionmaking, goal setting, health advocacy, and healthy self-management. THTM can be implemented in virtually any rural, urban, or suburban secondary school. THTM includes a series of instructional modules grouped by grade level. Approximately 90 45-minute THTM sessions are available at each of the following grade levels: 6-8, 9 and 10, 11 and 12. The developers of THTM recommend a "minimal dose" of 45 class sessions at each grade level.

Tinkham Alternative High School

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The Tinkham Alternative High School is a substance abuse prevention alternative high school program that serves at-risk students referred by local high schools. The Tinkham method employs broad-based and multifaceted social learning strategies. The heart of the program, service learning, is designed to provide students with opportunities to "give back" to the community by caring for others. Along with this experiential component, counseling, coaching, mentoring, tutoring, and referral are provided to offer comprehensive student assistance in their service endeavors. In addition, students with substance abuse problems are referred for ancillary services, and family counseling is available through the school's family resource center.

Urban Women Against Substance Abuse (UWASA)

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Urban Women Against Substance Abuse (UWASA) is a school-based program that focuses on Puerto Rican, Latina, and African- and Caribbean-American girls, and their female caregivers. UWASA is theoretically grounded in social learning theory demonstrating the connection between identified risk indicators—juvenile drug abuse violations, high school dropouts, teen birthrate, sexual abuse referrals—and the primary protective factors identified as cultural and community leadership by female adults. UWASA features a self-development curriculum that teaches girls to build cultural and gender identity, ATID knowledge, HIV awareness, and career options. Evaluations of UWASA revealed the success of this program in achieving a positive and significant effect on HIV/AIDS knowledge. Furthermore, treatment girls appeared to maintain substance use attitudes as healthy as those observed at baseline after the intervention.

Woodrock Youth Development Program

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The Woodrock Youth Development Program (YDP) is a school-based substance abuse prevention program designed to prevent or reduce alcohol, tobacco, and other drug use; raise awareness about the dangers of use; improve self-esteem, school attendance, and attitudes toward racial and ethnic diversity; and reduce aggressive attitudes and behaviors among at-risk elementary and middle school minority youth. YDP serves African-American, Latino, Asian, and Caucasian youth ages 6 through 14. Program youth attend public schools located in North Philadelphia, Pennsylvania. YDP schools are in economically depressed communities characterized by a high incidence of hate crimes, ethnic conflict, and drug trafficking. YDP can be implemented in other urban elementary and middle school settings. Despite strengths in the design and implementation of the evaluation, statistically significant improvements were evidenced for only half of the outcomes targeted. The absence of additional effects was attributed to insufficient intervention.

Effective Program Descriptions

Effective programs are science-based prevention programs that, in CSAP's terminology, build upon established theory, include elements and activities grounded in that theory, demonstrate practical utility for the prevention field, have been well implemented and well evaluated, and have produced a consistent pattern of positive outcomes. These programs must score at least 4.0 on NREPP's 5-point scale for the parameters of integrity and utility. On the following pages you will find brief descriptions and contact information for the following effective programs:

AIDS Community Demonstration Projects (ACDP)

Be Proud! Be Responsible!

Border Binge Drinking Reduction Program

Brief Alcohol Screening and Intervention for College Students (BASICS)

CASASTART

Challenging College Alcohol Abuse

Cognitive Behavioral Therapy for Child Sexual Abuse

Cognitive Behavioral Therapy for Child Traumatic Stress

Coping Power

East Texas Experiential Learning Center

Families and Schools Together (FAST)

Family Development Research Program

Family Matters

FAN (Family Advocacy Network) Club

Friendly PEERsuasion

Get Real about AIDS 1992

Good Behavior Game

High/Scope Perry Preschool Project

Home-Based Behavioral Systems Family Therapy

Houston Parent-Child Development Program

Mpowerment Project

Multi-dimensional Treatment Foster Care

Parenting Wisely

Popular Opinion Leader (POL)

Project STAR: Student Taught Awareness and Resistance

Prolonged Exposure Therapy (PE)

Promoting Alternative Thinking Strategies (PATHS)

Responding in Peaceful and Positive Ways (RIPP)

Rural Educational Achievement Project (REAP)

Schools and Families Educating Children (SAFE Children)

School Violence Prevention Demonstration Program

Second Step

Skills for Adolescence (SFA)

Skills, Opportunities and Recognition (SOAR)

SMART Leaders

Social Competence Promotion Program for Young Adolescents (SCPP-YA)

Stop Teenage Addiction to Tobacco (STAT)

Support for At-Risk Children

Team Awareness

Too Good for Drugs (TGFD)

AIDS Community Demonstration Projects (ACDP)

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The AIDS Community Demonstration Projects (ACDP) evaluated the effectiveness of using community volunteers to deliver a theory-based intervention designed to increase consistent condom and bleach use in a number of populations. The ACDP was a multi-site study of five U.S. cities: Dallas, Denver, Long Beach, New York City, and Seattle. Researchers from the project sites and the CDC collaborated with expert consultants to design a common protocol that was adapted to develop site-specific and population-specific community-level interventions. The target population consisted of a number of ethnically diverse, traditionally hard-to-reach, high-risk populations: men who have sex with men but who do not gay-identify (MSM-ngi), injecting drug users (IDUs) who are not recruited from treatment programs, female sex partners (FSP) of male IDUs, female prostitutes or sex traders (FST), and youth in high-risk situations (YHR). Each project intervened with one to three of these groups.

The behavioral intervention materials, in the form of small media, such as newsletters, brochures, flyers, or baseball cards, contained role-model stories. Each site produced unique materials with stories tailored to the local populations, based on the experience of local residents and highlighting specific stages of change and theoretical factors based on local data. The media also contained basic AIDS information; instructions on the use of condoms or bleach; biographies of community members participating in the project; or information on other health and social services, such as locations of homeless shelters or needle exchanges, free meals, mammogram screening, or drug and alcohol treatment services. At the community level, movement toward consistent condom use with main and non-main partners, as well as increased condom carrying, was greater in intervention than in comparison communities. At the individual level, respondents recently exposed to the intervention were more likely to carry condoms and have higher stage-of-change scores for condom and bleach use.

Be Proud! Be Responsible!

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Be Proud! Be Responsible! encourages low-income African-American adolescents in middle and high schools to be proud of themselves and their community, to behave responsibly for the sake of themselves and their community, and to consider their goals for the future and how unhealthful behavior might thwart those goals. The program aims to reduce HIV risk behaviors and increase condom use among African-American adolescents.

Participants receive a five-hour program designed to increase their knowledge of AIDS and sexually transmitted diseases and to weaken problematic attitudes toward risky sexual behaviors. Designed to be educational, but also entertaining and culturally sensitive, the program involves group discussions, videos, games, brainstorming, experiential exercises, and skills-building activities. It also includes information about risks associated with injection drug use and specific sexual activities. The intervention is based on the social cognitive theory, theory of reasoned action, and theory of planned behavior. The abstinence portion of the intervention is designed to: (1) increase knowledge of HIV and STDs; (2) strengthen behavioral beliefs supporting abstinence; and (3) increase self-efficacy and skills regarding peer pressure and negotiation. The safer-sex portion of the intervention is designed to: (1) increase HIV/STD knowledge and the belief that using condoms could prevent pregnancy and HIV/STD; (2) allay fears regarding adverse effects of condoms; and (3) increase skills and self-efficacy regarding their ability to use condoms.

One study reported that adolescents who received the intervention had greater AIDS knowledge, less favorable attitudes toward risky sexual behavior, and lower intentions to engage in such behavior than did those in the control group. Three-month follow-up data revealed that intervention adolescents reported fewer occasions of coitus, fewer coital partners, and greater use of condoms than did the other adolescents. Another study reported that the abstinence participants were less likely to report having sexual intercourse in the three months after intervention than were control group participants. Safer-sex participants reported significantly more consistent condom use than did control group participants at three months.

Border Binge Drinking Reduction Program

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The problem of underage and binge drinking in Mexico is a unique issue for communities along the United States-Mexico border. Differences in alcohol policies between the two nations such as drinking ages (18 in Mexico; 21 in the US), low-priced alcohol drinks in Mexico, and longer hours of alcohol sales have contributed to significant public health and public safety problems on both sides of the international border. The Border Binge Drinking Reduction Program is a coordinated effort focused on reducing cross-border teen and binge drinking in the San Diego-Tijuana region through a policy-focused, public health, prevention model.

The program targets teenagers younger than 18 years (who cannot legally enter Mexico without an adult family member), youths aged 18 to 20 years (who can drink legally in Mexico but not in the US), and young adults aged 21 to 25 years (who travel to Mexico to take advantage of lower alcohol prices and to accompany their younger friends who can drink legally only in Mexico). As police reports showed that weekend nights were when most young San Diego residents crossed into Tijuana and when most alcohol-related emergencies occurred, data collectors were placed at strategic points along the San Diego-Tijuana border on Wednesdays, Fridays, and Saturdays between 12 a.m. and 4 a.m. A police officer accompanying the interviewers randomly directed cars to the curb, where the interview took place. After the interviewer introduced him/herself, the motorist was informed about the aim and anonymity of the survey, that it was voluntary, the time required, and the breath sample.

Results of the effort conducted by PIRE at the San Diego-Tijuana border indicate that the number of minor pedestrians (younger than 18 years) crossing into Mexico on weekend evenings was reduced by 1,200 a month, the number of pedestrian crossers 18 years and older was reduced by 26 percent, the number of pedestrians younger than 18 years returning with measurable blood alcohol concentrations (BACs) was reduced by 40 percent, and the number of pedestrians with returning BACs higher than .08 was reduced by 29 percent. The number of arrests for violence and other problems in Mexico was reduced from 242 to 47 over a span of a year. The number of alcohol-related injury crashes involving 16- to 20-year-olds in San Diego was reduced by 45 percent.

Brief Alcohol Screening and Intervention for College Students (BASICS)

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BASICS (Brief Alcohol Screening and Intervention for College Students) is an intervention model under the general umbrella of Alcohol Skills Training Program, a skills-based curriculum that aims to reduce harmful consumption and associated problems in students who drink alcohol. BASICS targets heavy-drinking college undergraduates who either have experienced problems because of heavy consumption or are at high risk of doing so. The primary goal of BASICS is to move a student in the direction of reducing risky behaviors and harmful effects from drinking, as opposed to focusing explicitly on a specific drinking goal, such as abstinence or reductions in drinking. BASICS is nonlabeling, nonconfrontational, nonauthoritarian, and nonjudgmental.

BASICS is conducted over the course of two 50-minute interview sessions. In the first interview, the therapist assesses the student's consumption pattern. In the second interview, the therapist apprises the student of negative behavioral consequences from use of alcohol and other behaviors that may contribute to the student's health risks. Personalized feedback based on the assessment and specific advice about ways to reduce future health risks associated with alcohol use, are reviewed. Additional services can range from a single booster session of BASICS to more traditional outpatient or inpatient treatment.

A single-session, individualized preventive intervention was evaluated annually over four years, within a randomized control trial with college freshmen who reported drinking heavily while in high school. A randomly selected group from the entire screening pool provided a normative comparison. High-risk controls showed secular trends for reduced drinking quantity and negative consequences without changes in drinking frequency. The intervention group reported significant additional reductions, particularly with respect to negative consequences. Followup assessments in another two-year randomized control trial showed significant reductions in both drinking rates and harmful consequences, favoring students who received the intervention.

CASASTART

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CASASTART (Center on Addiction and Substance Abuse—Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered program designed to keep high-risk youth free of drug and crime involvement through a coordinated effort of preventive services and law enforcement activities. It operates on three levels: building resiliency in the child, strengthening families, and making neighborhoods safer for children and their families. The program targets youth between 8 and 13 years who attend a partner school and display risk factors known to be strong indicators of later involvement with substance abuse, delinquency, and academic failure. Every CASASTART child and family receive the following service components over the two-year period of participation: (1) social support/intensive case management, (2) family services, (3) education services, (4) afterschool and summer activities, (5) mentoring, (6) incentives, (7) community policing/enhanced enforcement, and (8) juvenile justice intervention. Participants receive all of the services through an individually tailored plan of service. The specific plans are based on the needs and strengths of the youths and families identified during the initial assessment phase.

Rigorous impact analyses found that children in the program, when compared to the matched control group at the one-year followup, were significantly less likely to use gateway and stronger drugs, less likely to report involvement in drug trafficking, and more likely to be promoted to the next grade in school. They also reported significantly lower levels of violent offenses, higher levels of positive peer influence, lower levels of association with delinquent peers, and less peer pressure.

Challenging College Alcohol Abuse

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Challenging College Alcohol Abuse uses social norms and environmental management strategies to prevent alcohol abuse among college-aged students. The program's primary target population consisted of all University of Arizona (UA) students. The three prevention arms of Challenging the Collegiate Rite of Passage are: 1) Social Norms Media Marketing Campaign, 2) Environmental Management, and 3) Moderation Skills Training.

The Social Norms Media Marketing Campaign is the primary component of Challenging College Alcohol Abuse. It targets students, resident advisors (RAs), parents, stakeholders, and others who may be reading school newspapers or are involved in other school-related activities or media. The campaign uses social marketing techniques and performs on-going research with the students on their alcohol use. Media materials typically include a photo of students, a normative message, credible data source, drink equivalency information, and a recognizable logo of the student health organization. Peer Health/Peer Educators (students) work with the program staff to help develop the media campaign. The messages strive to eliminate binge drinking by showing that their peers actually drink less than perceived. The Environmental Management component refers to policy changes and other environmental efforts at preventing high-risk drinking. A new component involves campus community strategies and efforts targeted at retailers, campus police, and others. These strategies, for example, include establishing safe-drinking standards at taverns and other facilities offering alcoholic beverages to college-aged students, and removing alcohol advertisements on campus. Moderation Skills Training is namely for students adjudicated on alcohol-related offenses. It includes the classes that are part of Challenging College ALcohol Abuse, such as SHADE, ANGLE, and CARE diversion classes.

Results show that negative consequences of alcohol and other drugs (AOD) use and positive perceptions of alcohol use decreased significantly. Heavy drinking decreased by 29 percent, as did AOD-related crimes. Also, key stakeholder data indicated more accurate perceptions of UA students' AOD consumption and negative consequences.

Cognitive Behavioral Therapy for Child Sexual Abuse

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Cognitive Behavioral Therapy (CBT) for Child Sexual Abuse is an empirically based treatment approach for children and adolescents ages 3 to 18 that addresses a wide range of trauma-related psychiatric symptoms in children that have been sexually abused. This program of individual and group therapy models for treating Post Traumatic Stress Disorder (PTSD) and related difficulties in children emphasizes enlisting the support of parents or primary caretakers, encouraging children to therapeutically process traumatic memories, changing children's dysfunctional cognitions and behaviors, teaching personal safety skills, and enhancing communication between children and their caregivers. This CBT approach is suitable for all clinical- and community-based mental health settings.

The treatment program consists of parallel individual sessions with the child and his/her nonoffending parent(s), as well as joint parent and child sessions. The treatment approach can be effectively implemented in 12 sessions. Specific components of treatment include: (1) psychoeducation about child sexual abuse and healthy sexuality; (2) coping skills training including relaxation, emotional expression, and cognitive coping; (3) gradual exposure and processing of traumatic memories and reminders; and (4) personal safety skills training. Parents also receive behavioral management training to strengthen children's positive behaviors, while minimizing behavioral difficulties. Joint parent-child sessions are designed to help parents and children practice and utilize the skills learned, while also fostering communication about the abuse and related issues. This treatment approach has been modified for use with children who have experienced other forms of abuse, such as physical abuse and exposure to domestic violence.

In a series of randomized control trials, this CBT approach led to significantly greater reductions in PTSD, depression, problem behaviors, and parental emotional distress, and resulted in greater improvements in personal safety skills in children. Research examining the impact of this treatment demonstrated the significant value of parental participation in treating acting out behaviors and depression, but the direct CBT work with the child seemed to be most critical in effectively treating PTSD in this population.

Cognitive Behavioral Therapy for Child Traumatic Stress

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Cognitive Behavioral Therapy (CBT) for Child Traumatic Stress is a research-based treatment model for children and adolescents ages 3 to 18 that addresses a wide range of trauma-related psychiatric symptoms seen in children suffering from traumatic bereavement following September 11, 2001. Individual and group therapy models for treating Post Traumatic Stress Disorder (PTSD) in children place emphasis on enlisting the support of parents or primary caretakers, encouraging children to therapeutically process traumatic memories, changing children's dysfunctional cognitions and behaviors, teaching safety skills, and building communication between adults and youth. This CBT approach is suitable for all clinical settings and most community-based mental health situations.

The 12 to 16 parallel individual sessions for parent and child address the following issues: (1) feeling identification; (2) cognitive coping/processing; (3) gradual exposure; (4) stress management; and (5) psychoeducation. Parents receive a behavioral management program to strengthen children's positive behaviors, while minimizing behavioral difficulties. In the aftermath of September 11, 2001, the manual for individual and group CBT was revised specifically for use by therapists treating children who lost loved ones as a result of the terrorist attacks. The revision was undertaken with support of the SAMHSA-funded National Child Traumatic Stress Initiative and its Traumatic Bereavement Task Force. The CBT protocol was modified to focus on traumatic bereavement, with the intent to deal with the child's trauma and grief symptoms.

In a series of randomized control trials, this CBT approach led to significantly greater reductions in post-traumatic stress disorder, depression, parental emotional distress, anxiety, problem behaviors, and sexually inappropriate behaviors. Research examining the impact of parent and child components of this treatment demonstrated the significant value of parental participation in treating acting out behaviors and depression. However, direct CBT work with the child seemed to be of critical importance in effectively treating PTSD in this population.

Coping Power

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Coping Power is delivered to moderate- to high-risk children in the late elementary school and early middle school years. The program lasts from 15 to 18 months and includes an integrated set of child and parent components. Coping Power is based on an empirical model of risk factors for substance use and addresses high-risk children's deficits in social competence, self-regulation, school bonding, and positive parental involvement. The Coping Power child component consists of 33 group sessions and periodic individual sessions and is delivered in school-based settings. The Coping Power parent component consists of 16 group sessions and periodic home visits and individual contacts. Post-intervention results indicate that the program has had effects on reducing children's aggressive behavior and preventing their substance use.

East Texas Experiential Learning Center

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The goal of the East Texas Experiential Learning Center is to reduce multiple risk factors for Alcohol, Tobacco, Other Drugs, Inhalants (ATODI) use and abuse among economically disadvantaged seventh graders in Nacogdoches, a rural East Texas community. The project consists of school-based intervention, afterschool trips, weekend day trips at local wilderness facilities and forest lands, Wilderness Challenge Ropes adventure camp for five-day sessions, and community-based programming.

Objectives of the project are to increase the perception of harm of ATODI use by high-risk youth and peers; increase negative attitudes toward ATODI use among youth, peers, family, school, and community; improve social competence; increase both cognitive and social problem-solving skills; increase feelings of autonomy among targeted youth; increase sense of purpose and future; increase high-risk youth involvement in alternative activities which do not include ATODI use; decrease level of conflict/violence at home, school, and community; enhance the climate at home, school, and community; increase the involvement of family, school, neighborhood, and community in dealing with ATODI problems; increase perception of harm of ATODI use; and increase parenting and teaching skills. The interventions used are adventure-based education; sharing and caring for the environment; development of community spirit and sense of responsibility; cognitive learning, including problem solving, negotiation, anger management and values enhancement; community training, including experiential learning, responsibility, consequences, and multicultural sensitivity; and a give-back program, including environmental community service projects and incentives that promote an investment by the youth in their community.

The program demonstrated the effectiveness of the social learning model within a risk factor approach in reducing risk factors for ATODI use and strengthening resiliency and protective factors, thereby reducing the incidence of ATODI use and related negative consequences.

Families And Schools Together (FAST)

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Families And Schools Together (FAST) is a collaborative parent-professional partnership, early intervention multi-family program for pre-school, elementary and middle school youth, ages 4 through 13, who are at risk for alcohol and other drug abuse, school failure, and juvenile delinquency. The program builds protective factors on multiple levels around children identified by teachers as being at risk for failure in school. FAST is now being implemented in over 450 schools in 31 states and five countries. The program targets families with 4- through 13-year-old children. FAST is an 8-week, multi-family group process structured to build social connections and reduce social isolation.

FAST activities include 1) an outreach process by trained FAST team partners who invite whole family participation in FAST with face-to-face visits at the parents'convenience, 2) an eight-week, multi-family engagement process for 8-12 families facilitated by a trained parent-professional partnership, and 3) an ongoing two-year FASTWORKS reunion process of monthly multi-family meetings of FAST graduates, run by the families and supported by the team.

Assessments of Wisconsin parents and children conducted on completion of the FAST program and at the 6-month followup, showed statistically significant improvement in children's classroom and home behaviors, family closeness, parental involvement in school, and a reduction in social isolation. Increased family friendships, community involvement, and parental self-sufficiency were documented in 2- to 4-year followup studies, suggesting that changes in the families'systems endured. California outcome data from 12 cities showed reduced conduct disorder, a predictor of future delinquent behavior, among FAST youth. Other published studies reported similar significant outcomes.

Family Development Research Project (FDRP)

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The Family Development Research Project (FDRP) began as an omnibus effort to serve low income, low education families by providing education, nutrition, health, safety, and human service resources for 108 families. The goal is to support child and familial behaviors that sustain growth and development after the intervention ceases. Home visitors, or CDTs (Child Development Trainers), visited each family weekly from before the birth of the baby until the child was five years old and graduated from the FDRP. FDRP targeted very deprived families (low in both income and education) early in the last trimester of pregnancy. Program curriculum was theoretically based on Erik Erikson and Jean Piaget's work, language development theory, and Saul Alinsky's ideas of empowerment of poverty families.

Program service delivery was divided into home visitation, infant-fold, and family-style delivery. Home visitation: CDTs visited 15 families each week demonstrating ways to nurture child development. Family problems—financial, emotional, social, and nutritional—were dealt with as they arose. Infant-fold: Infants were assigned to a caregiver for attention, cognitive and social games, sensorimotor activities, and language stimulation. Family-style: Preschoolers attended a multiage program that conceptualized the environment as supporting child-chosen opportunities for learning and peer interaction in a space—rather than time-oriented—framework.

When the children were teenagers, about 10 years after their graduation from the FDRP program, they were assessed again. More of the FDRPyouth expressed a liking for their own physical and personal attributes compared with the contrast group. Only 6 percent of the program youth in the followup sample were processed as probation cases by the County Probation Department, as compared to 22 percent of the control youth. Estimated juvenile court costs were also lower for program youth as compared with control youth. Education outcomes were not as remarkable for males as for females.

Family Matters

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Family Matters targets families with 12- through 14-year-old adolescents and helps families prevent teen alcohol and tobacco use. Family Matters is a universal prevention program because, in addition to including families with adolescents who do not use tobacco or alcohol, it includes adolescents who smoke or drink, and those who are at high risk for other reasons. The program involves successive mailings of four booklets to families and subsequent telephone contacts by a health educator. The materials used for implementing Family Matters are (1) four booklets mailed in succession to families, (2) the Health Educator Guidebook distributed to all health educators before training, and (3) pictures of small gifts included in the mailings. Each booklet begins with an overview and then proceeds with a question-answer section, a description of suggested activities, a summary of the main considerations, and a preview of the next part of the program. The guidebook covers all aspects of program implementation and includes all materials relevant to the program. The health educators receive two days of formal training, including monitored practice sessions. Training continues as the program is implemented.

Findings from the main evaluation study reported significant reductions in the prevalence of adolescent smoking and alcohol drinking in the intervention group at 3-month and 12-month followups. Another study suggested that smoking onset was significantly reduced at one-year followup for non-Hispanic whites. A published article reported that Family Matters was successful in changing several substance-specific aspects of family environment. Parents exposed to the program were more likely to set rules about tobacco and alcohol use, provide encouragement not to smoke, and talk about peer and media influences on alcohol use.

FAN (Family Advocacy Network) Club

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Web site: www.bgca.org

FAN (Family Advocacy Network) Club is designed for parents of participants in Boys & Girls Clubs of America's SMART Moves program, including Start SMART (ages 10 to 12), Stay SMART (ages 13 to 15), and SMART Leaders (for 14- to 17-year-olds who have completed the Stay SMART program). Combined with these other SMART Moves components, the FAN Club program can be implemented in community-based youth organizations, recreation centers, and schools, in collaboration with a local Boys & Girls Club.

This parent involvement program is offered in combination with a three-year sequential drug prevention program for early adolescents at high risk for substance abuse in Boys & Girls Clubs. FAN Club activities fall into four general categories: basic support, parent support, educational program, and leadership activities. The program strengthens families by creating a bond between youth and their parents, providing opportunities for families to have fun together, and helping parents influence their children to lead drug-free lives.

Friendly PEERsuasion

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Friendly PEERsuasion is a leadership and substance abuse prevention program, based on the social influence and life skills models of prevention. It is designed to help girls ages 11 through 14 acquire knowledge, skills, and support systems to avoid substance abuse. Underlying Friendly PEERsuasion is the theory that girls who are prepared to teach other children not to use substances would be less at risk of using those substances themselves. Through a process of "anticipatory socialization" (seeing themselves as future leaders), the girls trained to become PEERsuaders would be more likely to identify with the values and norms expressed by the staff than girls who had not undergone the training. The fundamental purpose is to build girls' capacity to become adults who are responsible, confident, economically independent, and personally fulfilled.

In the first phase, middle school girls participate in 14 biweekly, hour-long sessions facilitated by a trained adult leader. Through hands-on, interactive activities, they learn about the short- and long-term effects of substance abuse, experience healthy ways to manage stress, practice skills for making responsible decisions about drug use, and prepare to become peer leaders. After completing this phase, girls are certified as "PEERsuaders." In the second phase of the program, small teams of PEERsuaders working with adult leaders plan and implement 8 to 10 half-hour sessions of substance abuse prevention activities for children ages 6 through 10.

The program significantly reduced the incidence of drinking among participants and the onset of drinking among participants who had not previously drunk alcohol. The treatment group participants significantly increased leadership skills, stress-reducing skills, and communication skills. Treatment group participants also showed a significantly lower incidence of favorable attitudes toward drinking. The program led participants to disengage from peers who smoked or used drugs.

Get Real About AIDS 1992

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The primary aim of this school-based, skills-based HIV prevention intervention was to postpone the onset of sexual intercourse and reduce the percentage of students engaging in sexual and drug use behaviors that place them at risk for HIV infection. The intervention hoped to positively impact the students'knowledge, attitudes, and behavior related to HIV infection.

The intervention consisted of a 15-session, skills-based curriculum, a set of instructional materials reinforced the themes of the HIV curriculum. The curriculum was organized around two primary theoretical formulations: social cognitive theory and theory of reasoned action. Three of the lessons focused on HIV-related functional knowledge, one on teen vulnerability to HIV, two on the normative determinants of risky behavior, one on condom use, and eight on the development skills designed to help students identify, manage, avoid, and leave risky situations.

Intervention students exhibited greater knowledge about HIV and greater intent to engage in safer sexual practices than the comparison students. Among sexually active students at the six-month followup, intervention students reported fewer sexual partners within the past two months, greater frequency of using condoms, and greater intentions to engage in sex less frequently and to use a condom when having sex. Intervention students were also more likely to believe that teens their age who engage in HIV risk behaviors are vulnerable to infection.

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Good Behavior Game

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The Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) interventions seek to improve children's psychological well-being and social task performance. Both are implemented when children are in early elementary grades in order to provide students with the skills they need for responding to later, possibly negative, life experiences and societal influences. The Baltimore Mastery Learning intervention improves reading skills in order to combat learning problems and subsequent risk for depression. Like the Good Behavior Game, it utilizes a group-based approach in which students are assigned reading units and cannot advance until a majority of the class has mastered the previous set of learning objectives. The Good Behavior Game (GBG) is primarily a behavior modification program that involves students and teachers. It aims to decrease early aggression and shy behaviors to prevent later criminality. GBG improves teachers' ability to define tasks, set rules, and discipline students, and allows students to work in teams in which each individual is responsible to the rest of the group.

Evaluations of both programs have demonstrated beneficial effects for children at the end of first grade. At the end of first grade, ML students, compared to a control group, showed increases in reading achievement. At the end of first grade, GBG students, compared to a control group, had fewer aggressive and shy behaviors, according to teachers, and better peer nominations of aggressive behavior. At the end of sixth grade, GBG students, compared to a control group, demonstrated decreased levels of aggression for males who were rated highest for aggression in first grade.

High/Scope Perry Preschool Project

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The High/Scope Educational Research Foundation's principal goals are to promote the learning and development of children from infancy through adolescence and to support teachers, parents, and other adults who work with and care for children. The Foundation's continuing Perry Preschool Project is a longitudinal study of the effectiveness of preschool education for disadvantaged children. It has been influential in the continuation of Head Start and the expansion of other early childhood programs serving children at risk. The curriculum is implemented in State-funded pre-kindergarten programs, public and private half- and full-day preschools, child care centers, and family child care homes. Originally designed for low-income and at-risk children, the High/Scope approach is now used for the full range of preschool children.

The High/Scope Preschool curriculum, developed in the early 1960s as an open-framework instructional model, is based on Jean Piaget's constructivist theory of child development, along with traditional teacher experience. This approach includes (1) a curriculum for use with children of all backgrounds, (2) a training method to prepare staff to work effectively with children and families, and (3) a two-part assessment system that combines observational procedures to judge the quality of the program and document the progress of child growth. Children in High/Scope settings are encouraged to make choices about materials and activities throughout the day. As they pursue their choices and plans, children explore, ask and answer questions, solve problems, and interact with classmates and adults. The teachers do not directly teach academic skills through sequenced activities or "school-like" activities, rather they provide experiences and materials that help children develop broad language and logical abilities.

Longitudinal research, documented in a series of High/Scope Perry Preschool study reports, continues to demonstrate that at-risk children who attended the program do significantly better throughout childhood and adulthood than a comparable group of children who did not receive the High/Scope preschool experience.

Home-Based Behavioral Systems Family Therapy

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This family therapy approach is used with families of juvenile offenders, between 6 and 18 years of age, and those at risk for juvenile offending and substance abuse. It is a brief structured model delivered in five phases by paraprofessionals and professionals in the homes of at-risk families. The orientation is psychoeducational and relies on reducing family defensiveness, assessing needs coincident with healthy family relationships, and training parents and teens. Technical aids, such as the Parenting Wisely CD-ROM program and videotapes, are used at the beginning of treatment to increase commitment to the therapy, as well as decrease time in treatment.

The five phases of the program include: (1) Introduction/Credibility; (2) Assessment; (3) Therapy; (4) Education; and (5) Generalization/Termination. In the early phases, therapists are less directive and more supportive and empathic than in the later phases. This adapted model has been applied to multiple offending and institutionalized delinquents, targeting families with lower educational levels and higher levels of pathology than the original Functional Family Therapy Model developed. Modifications were made for families in Appalachia and for inner-city African-American families.

Long-range objectives include: reduced child involvement in juvenile justice system, reduced self-reported delinquency, reduced teen pregnancy, reduced special class placement, increased graduation rates, and increased employment. Intermediate objectives include: decreased family conflict; increased cohesion; improved communication; improved parental monitoring, discipline, and support of appropriate child behavior; improved problem solving abilities; improved parent-school communication; improved school attendance and grades; and improved child adjustment.

Houston Parent-Child Development Program

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The Houston Parent-Child Development program assists low income, Mexican-American families with one- to three-year-old children to help their children do well in school and foster intellectual and social competence. The program provides a wide range of educational and support services, delivers these services in ways that are responsive to the families' poverty and are culturally sensitive. Program guidelines call for (1) working with children from birth to three years of age, (2) training mothers to be effective teachers of their children, and (3) providing comprehensive services to counter the effects of poverty. The program is structured in two stages. The first, beginning when the index child is one-year-old, includes biweekly home visits to the mother and child, several weekend sessions for the entire family, English language classes for the mother, medical examination of the child, and assistance with accessing other community resources. In the second stage, mother and child participate in the program's activities four mornings a week. Activities include homemaker lessons in sewing, buying strategies, health and safety in the home, and group discussions on childcare and management. The entire program requires about 500 hours of participant time over a two-year period.

The Houston Parent-Child Development program was effective in training mothers, as demonstrated through comparing the program and a randomly assigned control group on several evaluation procedures. Program mothers were found to provide more appropriate play materials, be more emotionally and verbally responsive, and avoid restriction and punishment compared to mothers in the control group. For the children, significant differences were found on the Stanford-Binet Intelligence Scale when compared to the control group. A four-year followup study indicated that program children were less destructive, overactive, and negative attention-seeking, and were more emotionally sensitive compared to control children. Various other studies showed similar significant results.

MPowerment

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Mpowerment is a community-building program designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men. Developed through an intensive social marketing process with young gay men, the project is based on an empowerment model in which young gay men take charge of the project. This intervention was based on theories of Peer Influence and Diffusion of Innovations, which posit that people are most likely to adopt new behaviors when favorable evaluations of the behavior are conveyed to them by similar people whom they respect.

Mpowerment is run by a group of 10 to 15 young gay men from the community and paid staff. The young gay men from the core group, along with other volunteers, design and carry out all project activities. The program relies on a set of four integrated activities: formal outreach (teams of young gay men go to locations frequented by young gay men to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms), M-groups (young gay men discuss factors contributing to unsafe sex among men such as misconceptions about safer sex and poor sexual communication skills), informal outreach (young men discussing safer sex with their friends), and ongoing publicity campaign (campaigns that attract men to the project by word of mouth and through articles and advertisements in gay newspapers).

One study reported that following the intervention, the proportion of men engaging in any unprotected anal intercourse at baseline significantly decreased from 41 percent to 30 percent, decreased from 20 percent to 11 percent with non-primary partners, and decreased from 59 percent to 45 percent with boyfriends. No significant changes occurred in the comparison community over the same period.

Multi-dimensional Treatment Foster Care

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The Multi-dimensional Treatment Foster Care (TFC) program is a team approach based on a theoretical model of the development and maintenance of child behavior problems. TFC is an alternative to group or residential treatment, incarceration, or hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency.

Community families are recruited to provide TFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community. TFC emphasizes clear and consistent limits with follow-through on consequences, positive reinforcement for appropriate behavior, a relationship with a mentoring adult, and separation from delinquent peers. The program targets teenagers with histories of chronic and severe criminal behavior at risk of incarceration. In TFC, adolescents are placed, singly or in twos, in a family setting for six to nine months. Community families are recruited, trained, and supported to provide well-supervised placements and treatment. TFC parents are paid a monthly salary and a small stipend to cover expenses. The Core Components for Youth include daily structure and support, an individualized point system, a weekly individual treatment, consistent teaching-oriented nonphysical discipline, and psychiatric consultation and medication management as needed. The Core Components for Families include weekly family treatment with a strong skills focus, instruction in behavior management methods, frequent home visits with on-call and crisis backup, an aftercare parent group, and round-the-clock access to staff. The Core Components for Foster Parents include daily telephone calls, support and training, and round-the-clock staff availability and crisis intervention.

Evaluations of TFC have demonstrated that program youth compared to control group youth spent 60 percent fewer days incarcerated at 12-month followup, had significantly fewer subsequent arrests, ran away from their program three times less often, had significantly less hard drug use, and had quicker community placement from more restrictive settings. Results showed that youth spent significantly fewer days in lock-up during another one- and two-year followup study, and significantly fewer youth were ever incarcerated following treatment. There was a significant relationship between the number of days in treatment and the number of days of subsequent incarceration for youth in the TFC group.

Parenting Wisely

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Parenting Wisely (PW) is an interactive CD-ROM program designed to teach parents of delinquents and at-risk adolescents effective methods for improving family relationships by utilizing adaptive and effective parenting skills. It addresses communication skills, positive reinforcement, contingency management, and problem solving skills. The program instructs parents in effective parenting skills through the use of demonstration, quizzing, repetition, recognition, and rehearsal. This program is now being used in juvenile and divorce courts, mental health centers, community colleges and health centers, and Head Start centers. Parenting Wisely has been implemented in Australia, Ireland, England, Belgium, France, Germany, and Switzerland, as well as the United States.

The Parenting Wisely program package contains a CD-ROM, a service provider's manual for maximizing community impact, parent workbooks and certificates, referral cards, and brochures. The program teaches (1) communication, (2) assertive discipline, and (3) supervision. Each of nine case studies opens with a video of a common family problem. The problem is followed by positive and negative responses. Parents choose a response, see a video of how their choice would work, and get feedback on their choice. After choosing the best response, parents answer questions about the ideas and skills presented in the case.

One study reported not only significant improvements on three types of evaluative criteria (reaction, learning, and behavior), but also showed a substantial cost-benefit compared to other parenting interventions. Another study reported that the PW intervention group, at six-week and six-month followups, demonstrated significant improvement on measures of child problem behavior, parental depression, and general family functioning. A third study reported that mothers in the PW program showed increased knowledge of adaptive parenting practices and significantly lower frequency of child problem behaviors at one- and four-month followups. A study to investigate the effectiveness of the PW program for teenage parents found that the intervention group scored significantly higher on measures of parenting knowledge, belief in the effectiveness of adaptive parenting practices over coercive practices, and application of adaptive parenting skills to hypothetical problem situations. Other published studies have also reported significant improvements.

Popular Opinion Leader (POL)

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Popular Opinion Leader (POL) is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The program's target population includes gay men who frequent gay clubs/bars. POL is based on diffusion of innovation/social influence principles which states that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innovations are visibly modeled and accepted, they then diffuse throughout a population, influencing others. Based on population-wide surveys of all men patronizing gay clubs, a small cadre of popular "trendsetters" were identified, given training in approaches for peer education, and then contracted to communicate risk reduction recommendations and endorsements to their friends. The training consisted of four weekly sessions. Session one reviewed basic epidemiology of HIV infection, high-risk behavior, and precautionary changes to reduce risk. Session two described characteristics of effective health promotion messages, such as sensitizing others to the potential threat of AIDS. In session three, leaders modeled conversational examples which incorporated characteristics discussed in session two, such as role-playing. Session four reviewed the outcomes of the real-life conversations.

One study reported that the intervention consistently produced systematic reductions in the population's high-risk behavior (unprotected anal intercourse) from baseline levels, with the same pattern of effects sequentially replicated in three other cities. Another study reported a reduction in the number of men who engaged in unprotected anal intercourse (36.9 percent to 27.5 percent) and unprotected receptive anal intercourse (27.1 percent to 19 percent).

Project STAR: Students Taught Awareness and Resistance

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Project STAR, also known as the Midwestern Prevention Project (MPP), is a comprehensive, community-based drug abuse intervention program that uses school, mass media, parent education, community organization, and health policy programming to prevent and reduce tobacco, alcohol, marijuana, and other drug use by adolescents. Developed by the University of Southern California, the project first offers a series of classroom-based sessions for the school program during middle school that continue with the parent, media, community, and policy components. Project successes include the net reduction of 40 to 70 percent in drug use, including up to 40 percent in daily smoking among participants in the program thus far through early adulthood.

Prolonged Exposure Therapy (PE)

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Prolonged Exposure Therapy (PE) for post-traumatic stress disorders (PTSD) is a research-based treatment program that addresses a wide range of trauma-related psychiatric symptoms using focused, time-limited cognitive-behavioral therapies to provide adults with direct ways of coping with PTSD. The program targets female sexual/nonsexual assault victims with chronic PTSD and also other PTSD sufferers. The PE comprehensive theoretical model is suitable for all clinical settings and most community-based mental health situations. Exposure therapy is the most studied of the cognitive-behavioral therapies and has the most methodologically controlled studies revealing the strongest evidence of efficacy in the treatment of trauma. Foa's studies on PE have set the benchmark for all other trauma investigations. PE has been used in Australia, England, Holland, Norway, and other countries.

This program of manualized individual therapy for treating PTSD with adults places emphasis on preventing PTSD and treating PTSD, breathing retraining and psychoeducation, prolonged exposure therapy, in vivo exposure, imaginal exposure, and special issues. A PE manual for therapists chronicles the treatment sessions, homework assignments, audio taping requirements, and scripted instructions to facilitate this standardized cognitive-behavioral treatment protocol. The Center for the Treatment and Study of Anxiety instituted research and treatment programs for PTSD in rape victims in 1984. It offers cutting-edge cognitive-behavioral therapy programs that involve discussions about fearful thoughts, images, and beliefs; stress management training; and relaxation training.

In the initial study, PE was found to be more effective than supportive counseling. At three-month followup, PE revealed superior improvement in comparison to another treatment, stress inoculation training (SIT). PE, SIT, and a combination of the two were compared to a control group. PE showed superiority over SIT and PE-SIT on anxiety and depression (post-treatment), global social adjustment (followup), and had larger effect sizes for PTSD severity, depression, and anxiety. The study also revealed that combined treatment did not perform better than PE or SIT alone. At followup, PE had significantly greater improvements in PTSD, depression, anxiety, and anger over other treatments. Several authors have continued to show positive results with exposure therapy for Vietnam veterans, sexual assault, and a variety of traumas.

Promoting Alternative THinking Strategies (PATHS)

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The PATHS (Promoting Alternative THinking Strategies) curriculum is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school children. The goals are to promote the growth of productive, creative, competent, well-balanced children and to facilitate the development of a strong, healthy foundation prior to the onset of adolescence. The curriculum is designed to be used by educators and counselors in a multiyear, universal prevention model. Information and activities are also included for use with parents.

PATHS was developed for use in the classroom setting for children in Kindergarten through Grade 5. However, this program has been field-tested and researched with children in regular education classroom settings, as well as with a variety of special needs students (deaf, hearing-impaired, learning disabled, and emotionally disturbed students). The PATHS curriculum, taught three times per week, provides teachers with systematic, developmentally based lessons, materials, and instructions for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. PATHS lessons include instruction in identifying and labeling feelings, expressing and managing feelings, controlling impulses, reducing stress, interpreting social cues, understanding the perspectives of others, problem-solving and decision-making, and nonverbal and verbal communication skills. Teachers receive training in a two- to three-day workshop and in bi-weekly meetings with the curriculum consultant.

The PATHS curriculum has been shown to improve protective factors and reduce behavioral risk. Evaluations have demonstrated significant improvements for program youth compared to control youth in the following areas: self-control, understanding of emotions, ability to tolerate frustration, decreased anxiety/depressive symptoms (teacher report), decreased conduct problems (teacher report and child report), and decreased symptoms of sadness and depression (child report).

Responding in Peaceful and Positive Ways (RIPP)

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Funded by the Centers for Disease Control and Prevention, the Responding in Peaceful and Positive Ways (RIPP) program is a primary prevention program for violence to be implemented with the entire student population at a middle or junior high school. The goal of RIPP is to implement strategies that reduce risk factors (i.e., health-compromising factors) and increase protective factors (i.e., health-promoting factors), which will then lead to less violent, more positive behavior. RIPP employs a valued adult role model to teach students knowledge, attitudes, and skills designed to promote schoolwide norms for nonviolence and positive risk-taking. This is accomplished through the use of team-building activities, a social cognitive problem-solving model, repetition and mental rehearsal, relaxation techniques, role-plays, and a peer mediation program.

This program consists of a 25-session curriculum, RIPP-6, designed to be implemented in the sixth grade at middle schools (or seventh grade at junior high schools); 12-session booster programs, RIPP-7 and RIPP-8, designed to be implemented with seventh and eighth graders at middle schools (or with eighth and ninth graders at junior high schools); and a peer mediation program. A prevention facilitator is responsible for teaching the curricula and supervising the peer mediation program. The RIPP curriculum is typically taught in 50-minute sessions on a weekly basis throughout the school year during the academic subjects of social studies, health, and science.

In a within-school evaluation of RIPP, compared to control students, RIPP-6 students at post-test were significantly less likely to have disciplinary code violations for carrying weapons, were less likely to have in-school suspensions, had lower reported rates of fight-related injuries, and were more likely to participate in their school's peer-mediation program. RIPP-7 participants showed a significant increase in their knowledge of curriculum material and a trend for greater decreases in anxiety. At six-month followup, RIPP-7 students reported lower rates of peer pressure to use drugs and showed a significant increase in prosocial responses to hypothetical problem situations. In another study, compared to students at control schools, students at intervention schools reported more favorable attitudes toward nonviolence, less favorable attitudes toward violence, and greater knowledge of the material covered in the intervention. Significant differences on the frequency of aggression were found at post-test. An evaluation of RIPP-8 is currently underway.

Rural Educational Achievement Project (REAP)

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The Rural Educational Achievement Project (REAP) is a comprehensive, multilevel approach to prevention involving a universal prevention program (All Stars, Jr.), selective program delivered in the summer (Camp GUTS: Gearing Up To Success), and a family program (Duke Family Coping Power). The program targets fourth-grade students enrolled in elementary schools.

The All Stars, Jr., program is based on the character education and problem behavior prevention curriculum designed for middle school students. The focus draws from an individual's lifestyle, aspirations, social background, and other existing ideals that are likely to be incongruent with high-risk behaviors and builds or strengthens that perception in the student. The summer Camp GUTS (Gearing Up To Success) program is a selected six-week, protocol-driven, school-based program designed to strengthen academic and social competencies and self-esteem. The Duke Family Coping Power program is delivered to parents of high-risk students. The content, derived from social cognitive theory, provides parents with skills to deal with various aspects of child aggression. The program also includes sessions on stress management.

Program efficacy was designed around CSAP's four predictor variables: (1) academic achievement, (2) self-regulation, (3) social competence, and (4) parental investment. Findings for academic achievement indicated that this group showed greater gains in scores on a test of mathematics compared to two other groups. Subjects in the family and summer programs showed significantly higher levels of school bonding than the All Stars, Jr., only and control conditions. Findings for self-regulation indicated that the summer and All Stars, Jr., program had significant effects in decreasing externalizing behaviors. However, the results for social competence indicated that the family condition had lower baseline levels of social competence compared to the other conditions. The results for the parenting program suggested that the family condition had significant increases in the number of activities between parents and children.

Schools and Families Educating Children (SAFE Children)

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The SAFE Children program is a partnership between the Institute for Juvenile Research at the University of Illinois at Chicago and eight Chicago public schools. The program emphasizes helping families manage child development in risky environments. It is based on the "developmental-ecological model," which focuses on how characteristics of neighborhoods and schools affect children and family and determine how well a child does in school and later in life. The program aims to help with the transition to elementary school, make that first year successful, and set a firm base for the future. Families with children entering first grade and living in inner-city, high-crime neighborhoods are enrolled in a 22-week family program that emphasizes developing support networks among parents, improving parenting skills, and understanding schools and related child development issues. In addition, children are provided tutoring in reading to ensure mastery of basic reading skills in the first year of school.

School Violence Prevention Demonstration Program

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The School Violence Prevention Demonstration Program teaches middle and upper elementary school students civic knowledge and skills that affect those attitudes that serve as early warning signs of violence. The program has important implications for the way schools use alternate teaching strategies as well as education for democracy content, which may prevent violence while helping students develop into informed, effective, and responsible citizens.

Phase I, the first pilot year of the program, was conducted in seven U.S. school districts: Los Angeles Unified, Denver Public Schools, Jefferson County (Colorado) Public Schools, Wake County (North Carolina) Public Schools, Philadelphia Public Schools, Community School Districts 30 (Queens, New York) and 23 (Brooklyn, New York) Public Schools. The School Violence Prevention Demonstration Program includes three sets of materials: (1) "We the People…the Citizen and the Constitution" is a program that teaches essential concepts and fundamental values of the U.S. Constitution and the Bill of Rights. Critical-thinking exercises, problem-solving activities, and cooperative-learning techniques help develop the participatory skills necessary for students to become active responsible citizens. (2) "Foundations of Democracy: Authority, Privacy, Responsibility, and Justice" is a multidisciplinary curriculum that focuses on four concepts fundamental to an understanding of politics and government. (3) "We the People…Project Citizen" promotes competent and responsible participation in state and local government. Youth are actively engaged in learning how to monitor and influence public policy.

There were statistically significant gains in knowledge of the Constitution and the Bill of Rights in all seven sites and significant positive shifts in attitudes toward police and authority figures in six districts. There were significant gains between the experimental and control groups in students' sense of civic responsibility in Queens and Denver. There were statistically significant gains in tolerance for the ideas of others and including all people in the political and social process in Queens and Denver. Queens also had a positive shift in relation to authority and the law. Qualitative data suggested that teachers appreciated receiving high quality social studies textbooks, receiving quality teacher training in an important area of their responsibility, meeting with teachers from other schools and districts, and learning new teaching strategies.

Second Step

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Second Step is a school-based social skills curriculum for preschool through junior high that teaches children to change the attitudes and behaviors that contribute to violence. Second Step teaches three skill units at each grade level: empathy, impulse control, and anger management. The goals are to reduce aggression and promote social competence of children from preschool through grade 9. Currently, Second Step is being used by approximately 10,000 schools in the U.S. and Canada.

Second Step is intended for use with pre-kindergarten through Grade 9 students. The content of the lessons varies according to the grade level, and the skills targeted for practice are designed to be developmentally appropriate. At all grade levels, Second Step provides opportunities for modeling, practice, and reinforcement of skills. The curricula for preschool and elementary students consist of three kits: Preschool/ Kindergarten, Grades 1-3, and Grades 4-5. The lesson techniques include discussion, teacher modeling of the skills, and role-plays. These curricula include a song tape, puppets, a set of photo lesson cards, classroom posters, a teacher's guide, a classroom video, and a parent information video. The lessons in the Middle School/Junior High curriculum are divided into Foundation lessons and Skill-Building lessons. Each level includes discussion lessons, overhead transparencies, reproducible homework sheets, and a live-action video.

One study found that physical aggression and hostile and aggressive comments decreased among Second Step elementary students as opposed to the control group. Friendly behavior (prosocial, neutral interactions, and positive interaction) also increased in Second Step classrooms. Pilot tests for the middle/junior high curriculum revealed Second Step students were less likely to endorse relational aggression and perceive social skills as difficult to use than the control group. They also showed declines in endorsing physical and verbal aggression.

Skills for Adolescence (SFA)

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Lions-Quest's Skills for Adolescence (SFA) is a comprehensive school-based program that brings together parents, educators, young people, and other members of the community to support the development of life and citizenship skills in young adolescents within a caring and consistent environment. The program is specifically designed to address the developmental needs of young adolescents, ages 10 to 15 years, in public and private school settings. Funded by the CDC, NIDA, and Kellogg Foundation, SFA is based upon the rationale that identifies two major outcomes as critical for the promotion of social behaviors and reduction of health-compromising behaviors: (1) to develop positive social behaviors, such as self-discipline, responsibility, and good judgment; and (2) to develop positive commitments to their families, schools, peers, and communities, including a commitment to lead healthy, drug-free lives. Translated into 20 languages and in wide use in the United States, Canada, and 23 other countries, Skills for Adolescence has demonstrated its usefulness in diverse cultures and student populations.

Skills for Adolescence is comprised of five key components that provide schools with a structure for establishing a network aimed at addressing risk and protective factors related to reducing substance use, violence, and other health-compromising behaviors. These include: (1) classroom curriculum (103, 45-minute skills-building sessions that are offered in 12 formats, from a minimum nine-week mini-course to a maximum multi-year program); (2) parent involvement (parents participate in SFA through shared homework assignments, parent meetings, and school involvement); (3) positive school climate (staff, students, and parents establish a school climate committee to reinforce program goals and themes); (4) community involvement (staff, parents, and representatives from service organizations, business, and law enforcement take part in workshops, panel discussions, and projects); and (5) training (two- or three-day workshop models offer an overview of program components and hands-on experience to SFA implementers).

One-year post-intervention data from a study indicated that lifetime and recent (last 30 days) marijuana use was significantly lower in SFA than control schools. Post-test experimental students, when compared to comparison students, showed significantly improved knowledge about the risks of alcohol and other drugs; significantly higher perceptions of the harm to their health of drinking beer; significantly increased school attendance; significantly lower levels of current beer, liquor, and tobacco use; and significantly reduced intentions to use beer and liquor in the future (next 30 days). Two-year results from another study indicated that experimental students had half the rates of misconduct and truancy events compared to control students.

Skills, Opportunities, and Recognition (SOAR)

(formerly Seattle Social Development Program)

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SOAR is a scientifically tested comprehensive, school-based program designed to promote positive youth development and academic success. It is a schoolwide, school climate program for elementary schools that promotes the healthy development of young people by increasing skills for successful participation in the family, school, peer group, and community, and providing consistent recognition for effort and improvement. A SOAR school provides social skills training for elementary students, training for their teachers to improve methods of classroom management, and instruction on developmentally sequenced parenting workshops for parents. The long-term results indicate that students in SOAR classrooms are more committed to school and have better academic achievement and less misbehavior in the school and the community. SOAR was tested as the Seattle Social Development Project (SSDP), developed by Dr. J. David Hawkins and Dr. Richard Catalano of the University of Washington's Social Development Research Group, and is based on their social development theory.

SOAR is focused on the positive development of children in the elementary school grades. The objective is to make a significant impact on known risk and protective factors for substance abuse, violence and aggressive behavior, and academic success before the critical middle school years when children typically begin to engage in the range of risk behaviors. By increasing protection for children SOAR can help reduce the overall number of youth at-risk entering the middle school years.

Successful replication of SOAR involves installing SOAR over the course of two school years; program facilitator (a master classroom teacher) to assist teachers in implementation; family support coordinator; and coordination of the three basic components: school, peer, and family.

SMART Leaders

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SMART Leaders is a curriculum-based program that uses role-playing, group activities, and discussion to promote social and decisionmaking skills in racially diverse 14- to 17-year-olds. This program is a two-year booster program for youth who have completed Stay SMART, a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures. As participants advance in the program, they are involved in educational discussions on alcohol, tobacco, and drugs and have the opportunity to recruit other youth for the program and assist with sessions offered to younger boys and girls.

Evaluation results show the effectiveness of this multiyear approach in promoting refusal skills and creating drug-free peer leaders. The SMART Leaders program, with other SMART Moves components, can be implemented in community-based youth organizations, recreation centers, and schools, in collaboration with all local Boys & Girls Clubs. All the demonstration projects were implemented in Boys & Girls Clubs, a number of which are in or adjacent to public housing projects.

Social Competence Promotion Program for Young Adolescents (SCPP-YA)

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The 45-session Social-Competence Promotion Program for Young Adolescents (SCPP-YA) is a social and emotional learning program that has three modules. The first module includes 27, 40-minute lessons of intensive instruction in self-control, stress management, social problem solving, and communication skills. The other modules include 2, 9-session programs that teach students to apply these personal and social competencies to the prevention of substance use and high-risk sexual behavior. This one-year program has produced benefits with diverse fifth- through seventh-grade populations. It is most effective when offered in the context of coordinated, multiyear social development and health-promotion programming.

Stop Teenage Addiction to Tobacco (STAT)

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The Stop Teenage Addiction to Tobacco (STAT) initiative is an environmental campaign to enforce laws against tobacco use by minors and to stimulate communities to implement other strategies, such as banning vending machines or installing lockout devices on vending machines to curtail youth access to tobacco. While traditional youth smoking prevention initiatives have focused on reducing the demand or desire for tobacco among youth, the STAT effort focuses on cutting off the supply of tobacco to minors. The STAT effort targets law enforcement, vendors, and other community groups concerned with reducing the ability of minors to purchase tobacco. The aim of the program is to convince merchants to obey the law by refusing to sell tobacco to minors.

The town of Woodridge, Illinois, was the first in the Nation to put a tough enforcement program in place. As a result of this enforcement program, Woodridge's rate of tobacco use among teenagers was reduced by half.

Support for At-Risk Children

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The goal of the University of Oregon project on Substance Abuse Prevention in Preschool: Support for At-Risk Children (Project STAR) is to develop and investigate the effectiveness of a series of ecological, multidimensional interventions in impacting variables in the preschool years that are predictors of substance abuse. Project STAR developed and investigated the effectiveness of interventions designed to facilitate social competence, self-regulation, cognitive development and school bonding, and caregiver involvement. The program targets four-year-old children enrolled in Head Start classrooms. There were three components of the Project STAR intervention: (1) classroom-based intervention implemented by Head Start classroom teachers with training and coaching by Project STAR teacher consultants; (2) parent education and support groups conducted jointly by Project STAR staff and Head Start family advocates; and (3) individualized home visiting conducted by Project STAR home visitors. The classroom-based intervention curriculum provided training to Head Start classroom teachers in promoting children's social competence, self-regulation, language and early literacy skills. It also consisted of group activities for directly teaching critical skills within classroom circle times. The parent education and support component provided training and support on parenting and caregiver involvement to families of Head Start children. The individualized home visiting curriculum provided followup support to families on each of the risk factors targeted by this project.

Significant intervention effects were evident at the end of preschool on caregiver involvement and school bonding. Caregiver involvement effects were maintained a year later, after the kindergarten year. Additionally, significant effects were found for social competence. No significant intervention effects were found for self regulation.

Team Awareness

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Team Awareness for Workplace Substance Abuse Prevention is a team-based training program developed to increase the awareness of substance abuse as a group problem rather than an individual event. The training seeks to decrease tolerance and enabling of problem behaviors, enhance group responsiveness to problems, improve attitudes toward policy, and increase help seeking and peer referral to the EAP or other resources. Funded by NIDA, the major objectives of this worksite prevention training program are to examine and address the role that work group culture and social dynamics play in enabling substance use and how use by any member of the work group can negatively impact every other member. The training addresses five areas of workplace culture associated with substance use: occupational subcultures, drinking climates, tolerance/enabling, group cohesion, and the social context of policy.

The team-oriented awareness training is an eight-hour program, administered across two four-hour sessions, two weeks apart. Interviews and focus groups help customize training. The training is suitable for 9 to 15 employees to allow for group discussion. There are five training components: (1) relevance, which seeks to increase understanding of the importance of substance abuse prevention; (2) team ownership of policy, which explains that policy is most effective when seen as a useful tool for enhancing safety; (3) understanding stress, in which employees self-assess their coping style, identify stressors, and review methods for coping; (4) understanding tolerance, which teaches how tolerance can become a risk factor; and (5) support and encourage help, which encourages help-seeking and help-giving behavior.

A randomized control trial reported that group privacy regulation, EAP trust, help-seeking, and peer encouragement increased for the experimental group participants, while the control group showed no change. Stigma of substance users decreased only for the experimental group. A randomized field experiment that assessed the team-oriented training reported that experimental group supervisors were more likely than control group supervisors to improve on several dimensions of responsiveness. Another study determined that the need for this team-oriented approach is greater among employees who experience psychosocial risks, such as workplace drinking climates, social alienation, and policies that emphasize deterrence (drug testing) over educational prevention.

Too Good For Drugs (TGFD)

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Too Good For Drugs (TGFD) is a school-based prevention program designed to reduce risk factors and enhance protective factors relating to alcohol, tobacco and other drug use among students in kindergarten through high school (5 to 18 years old). Developed by the Mendez Foundation, Too Good For Drugs has a separate, developmentally appropriate curriculum for each grade level designed to develop:

- Personal and interpersonal skills relating to alcohol, tobacco and other drug (ATOD) use
- Appropriate attitudes toward ATOD use
- Knowledge of the negative consequences of ATOD use and benefits of a drug-free lifestyle
- Positive peer norms

Teaching methods are highly interactive and engage students through role-play, cooperative learning, games, small group activities and class discussions. Students have many opportunities to participate and receive recognition for their involvement. Teaching methods model and encourage bonding with prosocial others. TGFD also impacts students through a family component used in each grade level: "Home Workouts" is available for use with families in kindergarten through 8th grade, and "Home Pages" is used in high school.

Model Programs Consumer Summary Matrix

The chart that follows in this section shows various characteristics of the NREPP-rated model programs for comparison and to guide their selection by practitioners in the field. The matrix categories are described below.

Program. The first column in the table lists the name of the program, its developer, and the developer's institutional affiliation.

Target population. This column gives the age and the ethnic-racial background of the recipients on whom the program was tested.

Results. This column gives the length of measurement period that was used by the research design to show the program as effective. To qualify as science-based, a prevention program must include at least pretest and post-test data collections and analyses. In addition, most effective programs include at least one-year follow-up data. The research designs for many programs require follow-up measurements of three years or longer.

Replications. This column lists the number of times a model program has been tested. No replications mean that the program was evaluated only once, but resulted in its being shown effective and qualifying for model status. One or more replications show that a program was subjected to the indicated number of additional research studies beyond the original test.

Cultural adaptation. Because a number of model programs have been adapted for application with populations that differ from the original target population, this column describes the nature and extent of those adaptations.

Location. This column lists the settings in which a program has been implemented and tested.

Domain. Following CSAP conventions, each model program is categorized according to the domain(s) through which it reached its defined population. All programs occurred through more than one domain because of the nature of their focus and intervention delivery.

IOM category. The Institute of Medicine (IOM) defines prevention programs according to the manner in which they seek to engage their recipients. There are three categories: universal, selective, and indicated:

— *Universal* are programs that aim to reach all individuals, regardless of whether they, in fact, need a prevention program or will ultimately benefit from a prevention program. In this use of the word, universal means literally that the program is intended for the largest possible population of recipients. Universal programs are, therefore, classic public health interventions, designed to benefit those who need the programs by intervening with all members of the defined population.

— *Selective* interventions are prevention programs that aim to reach members of the population deemed at risk for the problem the program seeks to reduce or prevent. A selective program often employs sociodemographic profiles to identify characteristics of the at-risk group. For example, if certain economic conditions or neighborhood factors distinguish a population as having above-average risk for later substance abuse problems, members of groups who share those conditions or live in those neighborhoods would be designated for the selective prevention program.

— *Indicated* prevention programs are meant for individuals who, by lifestyle or behavior, already show evidence of having problems with substances, or whatever condition is targeted by the prevention program. Children who have experimented with drugs, for example, would be candidates for an indicated drug abuse prevention program.

Program activities. This column summarizes the major elements of the model programs. Contemporary approaches to prevention have multiple components, but only the major features can be included here.

Findings. Because every program listed in the table is, by definition, effective, the findings listed in this column summarize the program's major outcomes. Each item in the list is statistically significant, according to the research that documents the program.

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Across Ages Andrea Taylor Temple University	9-15 & Adults	Mixed						3+ 2 1	Replicated with Spanish-speaking children	Urban	Individual School Peer		• Adults mentor youth • Perform community service • Develop youth coping/life skills • Provide parent support	Improved school attendance and better understanding and attitudes toward older adults.
All Stars William Hansen Tanglewood Research	11-15	Mixed						3+ 2 1	Materials in Spanish	Urban Suburban Rural	Individual Family School Peer		• Develop positive peer norms • Increase bonding to school • Provide parent support	Reduced drug use, sexual activity, and reported violence; increased bonding with school and family.
Athletes Training and Learning to Avoid Steroids (ATLAS) Linn Goldberg Diane Elliot Oregon Health Sciences University	14-18 Males	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual School Peer Community		• Provide youth leadership training • Peer-led sessions • Develop resistance skills • Educate youth on sports nutrition	Reduced drinking/driving occurrences; decreased use of anabolic steroids, athletic supplements, and alcohol/illicit drugs.

Universal

Selected

Indicated

BEST COPY AVAILABLE

MODEL PROGRAM MATRIX

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Brief Strategic Family Therapy (BSFT) Jose Szapocznik University of Miami	8-17 & Families	Hispanic and African American						3+ 2 1	Tailored to work with Hispanic and African-American families	Urban Rural	Individual Family School Peer		• Provide problem- focused family therapy • Restructure maladaptive behaviors • Facilitate healthy family interactions training	Reduced drug use, and emotional and behavioral problems; improved family functioning.
Child Development Project (CDP) Eric Schaps Diane Wood Developmental Studies Center	6-12	Mixed						3+ 2 1	Some materials in Spanish	Urban Rural Suburban	Individual Family School Peer		• Develop youth coping and life skills • Increase bonding to school and peers • Enhance parenting skills	Decreased substance use; increased liking for school, enjoyment of class, and motivation to learn; greater conflict resolution skills.
Communities Mobilizing for Change on Alcohol (CMCA) Alexander Wagenaar University of Minnesota	<21	Mixed						3+ 2 1	No	Urban Suburban Rural	Peer Community Society		• Mobilize and organize communities • Enforce laws concerning alcohol sales to minors	Less likely to buy alcohol or drink in a bar; increased age-identification checking and reduced sales to minors; decreased arrests while driving under the influence.

Universal

Selected

Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Community Trials Intervention to Reduce High Risk Drinking (RHRD) Harold Holder Prevention Research Center	<21	Mixed						3+ 2 1	Materials in Spanish	Urban Suburban Rural	Community Society		• Mobilize & organize communities • Provide responsible beverage service training • Enforce laws concerning alcohol sales to minors	Reduced youth access to alcohol, sales of alcohol to minors, and alcohol-related automobile crashes.
Creating Lasting Family Connections (CLFC) Ted Strader Council on Prevention and Education: Substances, Inc.	11-15 & Parents	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual Family Community		• Develop youth coping/life skills • Provide individual/group counseling • Provide parent education/ training	Increased child resiliency; increase in setting family norms on substance abuse; delayed onset of substance abuse
Dare to Be You (DTBY) Jan Miller-Heyl Colorado State University	2-5 & Families	Mixed						3+ 2 1	N/A	Urban Suburban Rural	Individual Family School Community		• Provide peer mentoring • Develop life skills and coping skills in youth • Provide parent education training	Increased parent efficacy and increased child development skills.

Universal Selected Indicated

BEST COPY AVAILABLE

MODEL PROGRAM MATRIX

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Early Risers "Skills for Success" Gerald August University of Minnesota	6-9 & Parents	Mixed						3+ 2 1	Tested primarily with African American children and families	Rural	Individual Family School Peer		• Develop social skills • Enhance academic performance • Parent education and training	Improved social skills and academic achievement; increased parent involvement; reduced impulsivity.
Family Effectiveness Training (FET) Jose Szapocznik University of Miami Center for Family Studies	6-11 & Families	Hispanic						3+ 2 1	Tailored to work with Hispanic families	Urban Suburban Rural	Individual Family School Peer		• Target intergenerational and intercultural conflict • Restructure maladaptive behaviors • Facilitate healthy family interactions	Improved school performance; reduced problem behaviors; improved child concept and family functioning.
Incredible Years Carolyn Webster-Stratton University of Washington	3-10 & Parents	Mixed						3+ 2 1	Replicated with African American, Asian, and Hispanic families	Urban Suburban Rural	Individual Family School Peer		• Enhance social and academic competence • Develop youth coping and life skills • Provide parent education and training	Reduced problem behaviors; increased social competence and academic engagement.

Universal

Selected

Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Keep A Clear Mind (KACM) Chudley Werch Michael Young University of Arkansas	9-11 & Parents	Mixed						3+ 2 1	Some groups have translated materials in Vietnamese, Humong, and Spanish	Urban Suburban Rural	Individual Family Peer		• Develop resistance skills • Provide alcohol and drug information • Foster family support	Increased ability to resist pressure to use substances; increased parent discussions with children on substance use.
Leadership and Resiliency Program (LRP) Amrit Daryanani Fairfax Falls Church Community Services	13-18	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual School Peer Community		• Individual/group counseling • Increase bonding to school and family • Improve social competence	Reduced school absences and school disciplinary reports; increased GPA and graduation rates
LifeSkills Training (LST) Gilbert Botvin Cornell University Medical College Institute for Prevention Research	10-14	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer		• Enhance self-esteem • Teach interpersonal and communication skills • Develop resistance skills	Greater ability to refuse offers of alcohol, marijuana, and cigarettes; decreased rates of substance use; increased ability to find different ways to cope with stress.

Universal

Selected

Indicated

MODEL PROGRAM MATRIX

Program:	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Multisystemic Therapy Scott Henggeler Medical University of South Carolina	12-17 & Families	Mixed						3+ 2 1	Materials in Norwegian	Urban	Family Community		• Conduct family sessions at home • Enhance parenting skills • Improve family and peer relations • Improve school performance	Reduced long-term rates of rearrest and out- of-home placements; improved family functioning; decreased mental health problems.
Nurse-Family Partnership David Olds National Center for Children, Families, and Communities	>13 & unwed women; families bearing first child	Mixed						3+ 2 1	Spanish-speaking nurses were assigned to monolingual Spanish-speaking clients	Urban Rural	Individual School Community		• Conduct family sessions at home • Provide education on prenatal, infant, and early development • Build supportive relationships	Reduced cigarette smoking during pregnancy; reduced rates of child abuse; fewer subsequent births; fewer maternal behavior problems.
Olweus Bullying Prevention Dan Olweus University of Bergen	9-14	Mixed						3+ 2 1	Implemented in Bergen, Norway; southeastern U.S.; Sheffield, England; and Schleswig-Holstein, Germany	Rural Urban Suburban	Individual School Peer		• Restructure school environment • Increase positive involvement and supervision from teachers • Use consistent, non-hostile sanctions	Reduced students' reports of being bullied, bullying others, general anti-social behavior.

Universal Selected Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Positive Action (PA) Carol Gerber-Allred Positive Action, Inc.	6-18	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer Community		• Restructure school environment • Enhance self-management and social skills • Improve self-concept	Better achievement scores; fewer incidents of violence; fewer out-of-school suspensions; and fewer chronic absentees.
Preparing for the Drug-Free Years (PDFY) J. David Hawkins University of Washington	8-14 & Parents	Mixed						3+ 2 1	Tested with African American, Latino, and Samoan families	Rural Suburban Urban	Individual Family School Peer		• Provide family sessions • Enhance parenting skills • Improve family and peer relations • Develop youth coping and life skills	Reduced children's antisocial behavior; fewer incidents of drug use in school; improved parenting behaviors.
Project ACHIEVE Howard Knoff University of South Florida	5-13	Mixed						3+ 2 1	Replicated in Native American reservation schools/special education programs	Urban Suburban Rural	Individual Family School Peer		• Improve classroom management skills of school personnel • Enhance problem-solving skills • Increase social and academic progress	Decreased referrals to and placements in special education; decline in disciplinary referrals to principal's office; improved academic performance.

Universal Selected Indicated

MODEL PROGRAM MATRIX

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Project ALERT Phyllis Ellickson RAND	11-14	Mixed						3+ 2 1	Replicated in Spanish with special education programs, hearing impaired	Urban Suburban Rural	Individual Family School Peer		• Enhance decision-making, resistance, and interpersonal skills • Provide alcohol and drug information • Provide parent activities	Decreased marijuana use initiation; decreased current and heavy smoking; reduced pro-drug attitudes and beliefs.
Project Northland: An Alcohol Prevention Curriculum Cheryl Perry Carolyn Williams University of Minnesota	11-13	Mixed						3+ 2 1	No	Rural	Individual Family School Peer Community Society		• Provide alcohol and drug information • Provide peer mentoring • Enhance interpersonal skills • Provide parent education/ training	Reduced tobacco and alcohol use; decreased peer influence to use alcohol; improved parent-child communication about the consequences of alcohol use.
Project SUCCESS Ellen Morehouse Student Assistance Services	13-18	Mixed						3+ 2 1	Yes	Urban Rural Suburban	Individual Family School Peer		• Provide prevention education and referral services • Enhance youth-coping and life skills • Provide parent activities	Reduced alcohol, tobacco, and other drug use and problem behaviors.

Universal

Selected

Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Project Towards No Drug Abuse (TND) Steve Sussman University of Southern California	15-18	Mixed						3+ 2 1	Some materials in Persian	Urban Suburban Rural	Individual Family School Peer Community		• Enhance youth coping and life skills • Build resistance to peer pressure • Facilitate attitude change	Reduced higher levels of alcohol use and all levels of hard drug use.
Project Towards No Tobacco Use (TNT) Steve Sussman University of Southern California	10-15	Mixed						3+ 2 1	Some materials in Spanish	Urban Suburban Rural	Individual Family School Peer Community		• Teach interpersonal and decision-making skills • Build resistance to peer and media pressure • Facilitate attitude change	Reduced initiation of cigarettes; reduced initiation of smokeless tobacco; reduced cigarette smoking; eliminated smokeless tobacco use.
Reconnecting Youth (RY) Leona Eggert University of Washington School of Nursing	14-17	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer		• Build youth coping and life skills • Enhance interpersonal and decision-making skills • Provide peer mentoring	Improved school grades and attendance; reduced drug use and emotional distress; increased self-esteem, personal control, prosocial peer bonding, and social support.

Universal

Selected

Indicated

MODEL PROGRAM MATRIX

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1yr	2yr	3yr							
Residential Student Assistance Program (RSAP) Ellen Morehouse Student Assistance Services	14-17	Mixed						3+ 2 1	Yes	Urban Suburban Rural	Individual Peer Community		• Provide alcohol and drug information • Enhance interpersonal and decision-making skills • Provide individual, group, and peer counseling	Decreased alcohol, tobacco and marijuana use.
Start Taking Alcohol Risks Seriously (STARS) for Families Chudley Werch University of North Florida	11-13	Mixed						3+ 2 1	Yes	Urban Suburban Rural	Individual Peer Family School		• Enhance stress management and problem-solving skills • Provide alcohol and drug information • Promote family involvement	Reduced initiated alcohol use and heavy drinking over time.
Strengthening Families Program (SFP) Karol Kumpfer University of Utah	6-11 & Family	Mixed						3+ 2 1	Yes	Urban Suburban Rural	Individual Family School Peer		• Provide education services • Develop youth coping and life skills • Provide family strengthening and alternative drug-free activities	Decreased substance abuse; improved social/life skills; improved parent-child attachment/family relations; improved parenting skills.
Students Managing Anger and Resolution Together (SMART) Team Kris Bosworth University of Arizona	10-14	Mixed						3+ 2 1	No	Urban Suburban Rural	Individual Peer		• Present activities in form of motivational software • Teach anger management skills • Enhance decisionmaking skills	Improve knowledge of anger and anger management; greater frequency of self-reported prosocial acts; decreased beliefs of violence.

Model Programs

Model programs are effective programs whose developers have agreed to participate in CSAP-sponsored training, technical assistance and dissemination efforts. That help is essential to ensure that the program is carefully implemented and maximizes the probability for repeated effectiveness. On the following pages you will find detailed descriptions and contact information for the following model programs:

Across Ages

All Stars

Athletes Training and Learning to Avoid Steroids (ATLAS)

Brief Strategic Family Therapy

Child Development Project (CDP)

Communities Mobilizing for Change on Alcohol (CMCA)

Community Trials Intervention to Reduce High-Risk Drinking

Creating Lasting Family Connections

DARE To Be You (DTBY)

Early Risers "Skills for Success"

Family Effectiveness Training (FET)

Incredible Years Training Series

Keep A Clear Mind (KACM)

Leadership & Resiliency Program (LRP)

LifeSkills Training (LST)

Multisystematic Therapy (MST)

Nurse-Family Partnership (NFP)

Olweus Bullying Prevention Program

Positive Action (PA)

Preparing for the Drug-Free Years (PDFY)

Project ACHIEVE

Project ALERT

Project Northland:An Alcohol Prevention Curriculum

Project SUCCESS

Project Towards No Drug Abuse (TND)

Project Towards No Tobacco Use (TNT)

Reconnecting Youth (RY)

Residential Student Assistance Program (RSAP)

Start Taking Alcohol Risks Seriously (STARS) for Families

Strengthening Families Program (SFP)

Students Managing Anger and Resolution Together (SMART) Team

Across Ages

For information about implementation, costs, and training, contact:

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PROVEN RESULTS*

- Improved knowledge about and reactions to drug use
- Decreased alcohol and tobacco use
- Increased school attendance, decreased suspensions from school, and improved grades
- Improved attitudes toward school and the future
- Improved attitudes toward adults in general and older adults in particular

* The level of mentor involvement was positively related to improvement on various outcome measures.

Across Ages is a school- and community-based drug prevention program for youth 9 to 13 years old that seeks to strengthen the bonds between adults and youth and provide opportunities for positive community involvement. The unique and highly effective feature of Across Ages is the pairing of older adult mentors (age 55 and above) with young adolescents, specifically youth making the transition to middle school. The program employs mentoring, community service, social competence training, and family activities to build youths' sense of personal responsibility for self and community. Specifically, the program aims to:

- Increase knowledge of health and substance abuse and foster healthy attitudes, intentions, and behavior toward drug use among targeted youth
- Improve school bonding, academic performance, school attendance, and behavior and attitudes toward school
- Strengthen relationships with adults and peers
- Enhance problem-solving and decisionmaking skills

The overall goal of the program is to increase the protective factors for high-risk students in order to prevent, reduce, or delay the use of alcohol, tobacco, and illicit drugs and the problems associated with such use.

TARGET POPULATION

The original project and two replications were designed and tested on African-American, Hispanic, Caucasian and Asian-American middle school students (sixth grade) living in a large urban setting. More than 30 subsequent replications have been adapted for 9- to 13-year-old Native American, Caucasian, Hispanic, and African-American youth living in urban, suburban, and rural settings. Testing has shown that Across Ages is not appropriate for extremely rural communities because they do not offer the anonymity necessary for the youth-mentor relationship to work effectively.

BENEFITS

Participating youth have an opportunity to form a lasting relationship with a significant adult who can provide

Target Areas

Protective Factors To Increase

Individual
- Relationship with significant adult
- Engagement in positive free time activities
- Problem-solving/conflict resolution skills
- Bonding to school

Peer
- Association with peers engaged in positive behavior and activities

Family
- Engagement in positive family activities
- Improved communication between parents and children

School
- Improved school attendance, behavior, and performance

Community
- Youth given useful role in the community and viewed positively by community members

Risk Factors To Decrease

Individual
- Economic disadvantage
- School failure
- Identified behavior problems in school
- Lack of adult role models
- Poor decisionmaking and problem-solving skills

Peer
- Engagement in risky behavior

School
- Attendance at low-achieving and poorly staffed and funded schools
- Lack of bonding to school

Family
- Substance-abusing parents and siblings
- Incarcerated family members
- Little positive interaction between parents and children

Community
- Residence in communities with no opportunities for positive recreational activities, with high incidence of drug-related crime and pro-use norms

guidance, nurturing, and support. They learn positive coping skills and have an opportunity to be of service to their community. As a result, youth demonstrate an improved commitment to school, healthier attitudes and behaviors regarding nonuse of substances, a sense of social responsibility, and the capacity for positive problem solving.

HOW IT WORKS

Across Ages can be implemented as a school-based or after-school program. It has been replicated most successfully in urban/suburban settings where there is access to transportation **and** a sufficient number of older adults not personally known or related to participating families and youth. If the project is school-based, most of the activities for youth will take place in the classroom; if it is an after-school program, a school, community center, or faith-based institution are appropriate settings. The activities and interventions include Mentoring, Community Service, Social Competence Training and Family Activities

IMPLEMENTATION ESSENTIALS

To replicate with fidelity, programs must:
- Use all program components
- Have mentors who are 55 years or older
- Implement State or agency approved screening and training of mentors that includes 8 to 10 hours of preservice training and monthly inservice meetings
- Provide training and orientation for all participants
- Provide stipends or reimbursement to mentors
- Vigilantly monitor the mentor-youth matches
- Prepare written agreements between collaborating organizations
- Staff the program adequately (i.e., a minimum of one full-time and one part-time staff person for 30 youth and 15 to 20 mentors)

Resources

In addition to part-time clerical support, the program needs:
- Program Coordinator: One full-time college graduate with a minimum of 3 years experience in education, social work, counseling, or related field
- Outreach Coordinator: One individual who is familiar with the community, to recruit mentors and oversee community service, preferably working full time, but a part-time employee is acceptable

Timeline

Program planning and startup take about 6 months, including mentor recruitment and 2 days of preservice staff training. Two days of technical assistance (TA) during the first year and 1 day of TA in subsequent years are recommended. Across Ages requires 12 months of dosage for successful implementation.

PROGRAM BACKGROUND

Across Ages was developed at Temple University's Center for Intergenerational Learning in Philadelphia, PA. The project was originally funded in 1991 by the Center for Substance Abuse Prevention (CSAP) as a school- and community-based demonstration research project and was replicated in Philadelphia and West Springfield, MA, from 1995 to 1998. There are now more than 30 replication sites in 17 States.

All Stars™

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For program information, contact:

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PROVEN RESULTS

- Increased commitment to avoid substance use and other high-risk behaviors
- Increased adoption of a belief in positive peer group norms that make substance use, violence and premature sexual activity unacceptable
- Reduced substance abuse by 40% to 60%*
- Reduced sexual activity 80%
- Increased belief that substance use and high-risk behaviors would interfere with one's desired lifestyle
- Increased bonding to school

* At immediate posttest.

All Stars™ is a school- or community-based program designed to delay the onset of and prevent high-risk behaviors in middle-school-age adolescents 11 to 14 years old. It affects youth substance use, violence and premature sexual activity by fostering development of positive personal characteristics. A highly interactive program, All Stars involves 9 to 13 lessons during its first year, and 7 to 8 booster lessons in its second year.

All Stars is based on strong research that has identified the critical factors that lead young people to begin experimenting with substances and participating in other high-risk behaviors. The program is designed to reinforce positive qualities that are typical of youth at this age; it works to strengthen five specific qualities that are vital to achieving preventive effects:

- Developing positive ideals and future aspirations
- Establishing positive norms
- Building strong personal commitments
- Promoting bonding with school and community organizations
- Promoting positive parental attentiveness

All Stars is available in formats for delivery in schools as part of regular classroom instruction, and in after-school and community-based organizations and programs.

TARGET POPULATION

The All Stars core program targets young adolescents before they have begun to participate in the targeted risky behavior, typically sixth and seventh graders; however, program initiation depends on the school system's structure. The booster program is designed for implementation 1 year after the core sessions. All Stars has been tested in rural, suburban, and urban settings with children from diverse ethnic and socioeconomic backgrounds, at sites in Arizona, Colorado, Florida, Georgia, Illinois, Kentucky, Massachusetts, Montana, Nebraska, North Carolina, Oregon, Texas, and Washington.

All Stars Junior (currently under evaluation) is designed as a preparatory intervention for fourth and fifth grade students, and is taught as part of science, math, and language arts classes. All Stars Senior (also currently under evaluation) is designed as a high school followup taught in health classes.

Target Areas

Protective Factors To Increase

Individual
- Idealism and an orientation toward the future
- Belief in conventional norms
- Commitment to avoid high-risk behaviors

Peer
- Visibility of positive peer opinion leaders
- Establishment of conventional norms about behavior

Family
- Communication with parents
- Parental monitoring and supervision
- Establishment of clear rules and standards
- Expressions of love and affection
- Discipline at times when it is ppropriate
- Motivation to provide a good example

School
- Bonding to school
- Student–teacher communication
- Parental support for school prevention activities

Community
- Commitment to be a productive citizen
- Participation in community-focused service projects

Risk Factors To Decrease

Individual
- Perceived pressure to participate in substance use

Peer
- Offers and pressure from peers to use substances
- Identification and exclusion of negative peer role models

Family
- Parental tolerance of deviance

OUTCOMES

Short-term results for All Stars indicated:
- Improvements in each of the risk and protective factors targeted by the program
- A reduction in substance use
- A delay in the onset of sexual activity
- Better results with the teacher format than the specialist format

BENEFITS

- Emphasizes the development of positive character and positive environments
- Promotes positive norms that support the choice to avoid high-risk behaviors
- Promotes perceptions that high-risk behaviors will interfere with desired and valued lifestyles
- Strengthens bonds to positive social groups and institutions that promote positive values
- Increases the amount of positive attention young adolescents receive from parents and other respected adults

HOW ITWORKS

All Stars is a guided multiyear program that is delivered to all students or group members on a weekly basis. The program is packaged in three different formats (Teacher, Specialist and Community), each designed to meet a specific need. In each format, students are engaged through:

- Small group activities
- Group discussions
- Enjoyable and meaningful worksheet tasks
- Videotaping
- Games and Art activities

IMPLEMENTATION ESSENTIALS

Training

A 2-day training session, provided by Tanglewood Research staff and authorized trainers, is highly recommended for teachers and anyone who plans to deliver the program. Teachers who have run the program report (as preliminary research also suggests) that continued training significantly boosts program effectiveness. Training includes:
- A thorough explanation of key concepts that underlie the program
- An introduction to methods, including strategies for addressing unanticipated events
- Continuing toll-free telephone technical assistance

Materials

Materials are purchased directly from Tanglewood Research. Order forms are available at www.tanglewood.net/products/allstars/ All_Stars_Order_Form.pdf. All costs are documented on the order form. Reusable materials include teacher manuals, a movie slate (for use with videotaping sessions), and an All Stars banner. Consumable materials include student worksheets, special forms for certificates, software for producing certificates, parent CDs, and a $20 gift certificate for purchasing office supplies and student prizes.

ATLAS (Athletes Training and Learning to Avoid Steroids)

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PROVEN RESULTS

- New substance use decreased 50%
- New anabolic steroid use decreased 50%
- Occurrences of drinking and driving declined 24%
- Lower index of alcohol and drug use
- Reduced use of performance-enhancing supplements
- Improved nutrition and exercise behaviors

ATLAS (Athletes Training and Learning to Avoid Steroids) is a multicomponent school-based program for male high school athletes (13 to 19 years old). It capitalizes on team-centered dynamics and uses positive peer pressure and role modeling to reduce the use of:

- Anabolic steroids
- Alcohol and other drugs
- Performance-enhancing supplements

Delivered to a school sports team, with instruction led by student athlete peers and facilitated by coaches, ATLAS promotes healthy nutrition and exercise behaviors as alternatives to substance use. The 10-session curriculum is highly scripted and contains interactive and entertaining activities that make it easy and desirable to deliver, enhancing the fidelity of the intervention. The product of 10 years of research and field testing, ATLAS focuses specifically on adolescent male athletes' risk and protective factors.

PROGRAM BACKGROUND

ATLAS was initiated in 1993 with funding from the National Institute on Drug Abuse (NIDA). NIDA wanted a program designed to reduce or stop adolescent male athletes' use of anabolic steroids, sport supplements, alcohol, and illicit drugs, while improving healthy nutrition and exercise practices. The program was tested in a randomized controlled setting at 31 schools, in 12 cities and 2 States (Oregon and Washington) with more than 3,200 participants. The NIDA randomized study was based on 4 years of prior research among more than 1,500 male athletes in 16 high schools in smaller, yearly randomized controlled trials.

TARGET POPULATION

The ATLAS program is designed for male student athletes in grades 9 to 12, although it has been used with younger athletes. The program has been successfully implemented in urban and rural schools with participants from diverse racial, ethnic, and socioeconomic backgrounds.

Target Areas

Protective Factors To Increase

Individual
- Decisionmaking skills
- Sports nutrition knowledge
- Perception of personal athletic competence
- Athletic self-efficacy
- Exercise skills
- Reasons for not using drugs
- Proper nutrition and eating behaviors
- Perception of drug risks
- Knowledge about steroids, alcohol, and other substances of abuse

Peer
- Peers as source of correct information

School
- Team as a source of information
- Exercise and use of school gym
- Coaching staff intolerance to substance use

Risk Factors To Decrease

Individual
- Negative peer pressure

Community
- Belief in media advertisements promoting performance enhancing products

OUTCOMES

One year after the intervention, relative to the control groups, students who participated in ATLAS showed:

- Reduced intent to use anabolic steroids
- Greater substance use resistance skills
- Reduced substance abuse risk factors (e.g., less belief in media advertisements)
- Improved substance abuse protective factors (e.g., better nutrition behaviors, improved perception of athletic competence)
- Increased number of reasons not to use anabolic steroids
- Greater perception of the team and peers as an information source
- Improved knowledge of alcohol, marijuana, and anabolic steroids

BENEFITS

ATLAS trained students demonstrate:

- Improved substance use resistance skills
- Higher perceived personal susceptibility to the harmful effects of drugs
- Increased belief that their coach will not tolerate steroid use
- Improved perception of their personal athletic competence
- Reduced drinking and driving occurrences

HOW IT WORKS

ATLAS is delivered in a classroom to an entire sports team. Students are divided into small social learning groups with a peer (squad) leader for each group. ATLAS' team-centered approach works to exert positive peer pressure and promote positive role modeling. It is easy to implement, because it is highly scripted with explicit instructions.

IMPLEMENTATION ESSENTIALS

A 1-day training program, offered by the program developer, is not required but is recommended for school districts with multiple teams and coaches. Training will enhance the fidelity of the curriculum delivery. Successful replication of ATLAS also requires:

- A highly committed coach-facilitator
- A coach "Instructor Package" which includes:
  - —Program background information
  - —Squad Leader Training Guide (explains how to train effective squad leaders)
  - —Ten-Session Curriculum Guide
  - —Overhead slides
- Use of Student Materials (workbook, sports menu, and Training Guide booklets)
- Team-based presentation of the program with one peer leader in each small group (i.e., squad) of six to eight students
- Ten-Session Curriculum Guide for each peer leader (this may be photocopied)

Brief Strategic Family Therapy (BSFT)

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Information on costs, materials, and ongoing technical assistance can be obtained from:

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Web site: www.cfs.med.miami.edu

PROVEN RESULTS*

- 42% improvement in conduct problems
- 75% reduction in marijuana use
- 50% reduction in association with antisocial peers
- Retained over 75% of youth in program

* Relative to comparisons.Different tests focus on changes over time between treatment and comparison groups.

Brief Strategic Family Therapy (BSFT) is an effective, problem-focused, and practical approach to the elimination of substance abuse risk factors. It successfully reduces problem behaviors in children and adolescents, 6 to 17 years, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies that strengthen families. It targets:

- Conduct problems
- Associations with anti-social peers
- Early substance use
- Problematic family relations

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach strategies to bring families into therapy.

PROGRAM BACKGROUND

BSFT was developed at the Spanish Family Guidance Center in the Center for Family Studies, University of Miami. BSFT has been conducted at these centers since 1975. The Center for Family Studies is the nation's oldest and most prominent center for development and testing of minority family therapy interventions for prevention and treatment of adolescent substance abuse and related behavior problems. It is also the nation's leading trainer of research-proven, family therapy for Hispanic families.

TARGET POPULATION

BSFT helps children and adolescents 6 to 17 years old who exhibit rebelliousness, truancy, delinquency, early substance use, and association with problem peers. BSFT also benefits families that are affected by poor behavior management, parental discord, anger, blaming interactions, and other problematic relations. This program was tested and proven in Hispanic families and adapted and tested with African-American families.

OUTCOMES

In children and families:

- Reductions in conduct and emotional problems

Target Areas

PROTECTIVE FACTORS TO INCREASE

Individual
- Bonding to family and school
- Positive self-concept
- Positive transition into adolescence
- Problem-solving skills
- Good school attendance, conduct, and achievement

Family
- Appropriate levels of parental involvement with youth, their schools, and their peers
- Effective parental leadership and behavior management
- Effective parent-child communication
- Effective family conflict resolution, problem solving, and decisionmaking skills
- Appropriate parental support and family cohesiveness
- Effective parenting skills in managing youths'peer relations

RISK FACTORS TO DECREASE

Individual
- Behavior problems at school and at home
- Lack of self-discipline
- Poor tolerance for frustration
- Early anti-social behavior
- Association with anti-social peers
- Unconventional beliefs or attitudes

Family
- Parent-child conflict
- Angry and blaming family interactions
- Conflict among parent figures
- Family isolation
- Ineffective parental behavior control
- Parental or older sibling involvement with drugs

- Improvements in self-concept
- Improvements in family functioning

In adolescents and families:
- Reductions in conduct problems
- Reductions in association with antisocial peers
- Reductions in substance use
- Improvements in family functioning
- Increased family participation in therapy

BENEFITS
- Improves youth's self-concept and self-control
- Reduces youth behavior problems, substance use, and association with antisocial peers
- Increases parental involvement and develops more positive and effective parenting
- Makes parental management of children's behavior more effective
- Improves family cohesiveness, collaboration, and child bonding to the family
- Improves family communication, conflict resolution, and problem solving skills

HOW IT WORKS

BSFT can be implemented in a variety of settings, including community social services agencies, mental health clinics, health agencies, and family clinics. BSFT is delivered in 8 to 12 weekly 1 to 1.5 hour sessions. The family and BSFT counselor meet either in the program office or the family's home. Sessions may occur more frequently around crises because these are opportunities for change.

IMPLEMENTATION ESSENTIALS

Trained counselors who can implement the program as tested are required for successful replication. The ideal counselor has a master's degree in social work or marriage and family therapy. However, individuals with a bachelor's degree and experience working with families may qualify. One full-time counselor can provide BSFT to 15 to 20 families for in-office sessions and 10 to 12 families for in-home sessions.

Administrative support is key to successful BSFT replication. BSFT requires an agency that is open at times that are convenient for participating families, provides transportation and, if needed, provides childcare when sessions are conducted in the office.

Training and technical assistance is available through the Center for Family Studies' Training Institute. The Institute provides a broad range of training programs in Miami or will train onsite at agencies around the country. Training is tailored to agency needs and populations and offered in Spanish and English.

Startup takes about 1 year, including hiring and training of counselors, developing community referral resources, and recruitment and screening of referred families.

Child Development Project (CDP)

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PROVEN RESULTS*

- Alcohol use declined from 48% to 37% of students
- Cigarette use declined from 25% to 17% of students
- Marijuana use declined from 7% to 5% of students
- Other risky behavior declined, including carrying weapons, threats of violence, and involvement in "gang fights"

* Among fifth and sixth grade students in school that fully implemented CDP.

The Child Development Project (CDP) is a multifaceted, schoolwide improvement program that helps elementary schools become "caring communities of learners" for their students (5 to 12 years old). CDPsignificantly reduces children's early use of alcohol and marijuana and their involvement in violence-related behavior. CDPis designed to strengthen connections among peers and between students of different ages, teachers and students, and home and school, in order to promote:

- School bonding-students'commitment to, and engagement in, their school
- Students'interpersonal skills and commitment to positive values
- Classroom and school-wide climate of safety, respect, caring, and helpfulness

The program, which involves students in all grade levels, their families, teachers, and school administrators, prepares children to play responsible roles in their classrooms and schools so that later they can contribute to the wider society. The program has recently been streamlined and strengthened to make it more feasible and affordable to implement, and more effective at boosting literacy skills.

PROGRAM BACKGROUND

The Child Development Project has been developed over the past 20 years through a series of demonstration studies and revisions. It has been rigorously implemented and evaluated in such diverse settings as Dade County, FL, White Plains, NY, Louisville, KY, and San Francisco, Salinas, and Cupertino, CA. Copies of various evaluation studies, assessment instruments, program descriptions, and program materials are available from its developer, the non-profit Developmental Studies Center in Oakland, CA.

TARGET POPULATION

The original CDP student population varied widely: 2 percent to 95 percent of children were receiving free or reduced-price lunch (a measure of socioeconomic status), and 26 percent to 100 percent were minority group members. The program can be implemented in any rural, suburban, or urban elementary school.

OUTCOMES

Target Areas

Protective Factors To Increase

Individual
- Healthy ethical, social, and emotional development
- Commitment to prosocial values

School
- Attachment (bonding/connection) to school
- Strong sense of community among students in school
- Academic engagement and success
- Caring relationships with teachers

Peer
- Caring relationships with peers

Risk Factors To Decrease

Individual
- Early antisocial behavior
- Lack of self-control, assertiveness and other social/emotional skills
- Lack of commitment to core societal values

School
- School failure
- Lack of school bonding
- Low sense of community in school
- Lack of family involvement in schooling

Although issues of substance abuse are not directly addressed in the CDP program, a comprehensive evaluation of the program shows that when well implemented, it produces significant preventive effects on students'use of alcohol and marijuana, and marginal effects on use of tobacco.

In schools where the program led to widespread change in teaching practices, the following effects were shown:

- Prevalence of alcohol use declined by an average 11% over 4 years in CDP schools, compared with an increase of 2% in matched comparison schools.
- Prevalence of marijuana use by CDP students declined by 2% compared with a 2% increase by comparison school students.
- Prevalence of cigarette use by CDP students declined by 8% compared with a 3% decline by comparison school students.

BENEFITS
- Creates an atmosphere of trust and respect between students and teachers
- Nurtures responsibility, fairness, honesty and helpfulness in students
- Enhances students' conflict resolution skills
- Increases students'academic motivation
- Strengthens family-school-community connections

HOW IT WORKS

CDP is implemented in two phases. Phase I focuses on building a strong sense of the school and classroom community, while Phase II focuses on building students'literacy skill and interpersonal skills.

IMPLEMENTATION ESSENTIALS

Training for Phase I

There are a range of options for professional development to introduce a school's staff to Phase I. These include: 1) a one-day introductory workshop to introduce all four components of Phase I; 2) a two-day introductory workshop, the second day of which focuses on the class meeting component; 3) a one-day class meeting workshop, and 4) a two-day class meeting workshop. (The class meeting-specific workshops are offered because this is typically the most challenging component for teachers to implement.) For districts or small groups of schools located in one region, a cost-saving, three-day training-of-trainers (TOT) workshop is offered. Follow-up visits by DSC staff developers are also available to provide coaching and consultation. Fees for workshops and follow-up visits are $1200 per day, plus travel expenses.

Materials for Phase I
- At Home in Our Schools: one book for each member of a coordinating team of staff and parents
- That's My Buddy: one book for each teacher
- Ways We Want Our Class To Be: one book for each teacher
- Homeside Activities: one grade-level book for each teacher

Materials cost approximately $50 per teacher.
Please contact DSC for more information about training and costs for Phase II components.

Communities Mobilizing for Change on Alcohol (CMCA)

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PROVEN RESULTS

- Alcohol merchants increased age checks and reduced alcohol sales to minors
- Youths 18 to 20 years old reduced the practice of providing alcohol to younger teenagers
- Youths 18 to 20 years old were less likely to try to buy alcohol, drink in a bar, or consume alcohol
- Arrests for driving under the influence of alcohol declined significantly among 18 to 20 years olds

Communities Mobilizing for Change on Alcohol (CMCA) is a community-organizing program designed to reduce adolescents' (13 to 20 years old) access to alcohol by changing community policies and practices. Initiated in 1991, CMCAhas proven that effectively limiting the access to alcohol to people under the legal drinking age not only directly reduces teen drinking, but also communicates a clear message to the community that underage drinking is inappropriate and unacceptable.

CMCAemploys a range of social organizing techniques to address legal, institutional, social, and health issues in order to reduce youth alcohol use by eliminating illegal alcohol sales to youth by retailers and obstructing the provision of alcohol to youth by adults.

TARGET POPULATION

CMCA can be implemented in virtually any rural, suburban, or urban community. The program targets interventions at all members of a community. Communities from Minnesota and Wisconsin participated in the initial program evaluation.

BENEFITS

The CMCA project:

- Mobilizes communities to make institutional and policy changes
- Limits youth access to alcohol
- Improves the health of the community

OUTCOMES

Results show that the CMCA intervention:

- Significantly and favorably affected the drinking behavior of 18- to 20-year-olds
- Significantly and favorably affected the practices of establishments serving alcohol
- May have favorably affected the practices of alcohol package sales establishments

Other outcomes include:

- Alcohol merchants increased age-identification checking and reduced propensity to sell to minors

Target Areas

PROTECTIVE FACTORS TO INCREASE

Community
- Institutional policies that discourage youth alcohol use
- Public and institutional policies that reduce alcohol sales to youth
- Civic action against illegal sale and provision of alcohol to youth
- Increased interaction among diverse community sectors

RISK FACTORS TO DECREASE

Peer
- Peers providing alcohol
- Peers using alcohol

Community
- Easy availability of alcohol
- Normative support of alcohol sales to underage youth
- Normative support of alcohol consumption by underage youth
- Poor enforcement of alcohol laws and regulations
- Lack of laws or institutional policies that limit alcohol availability

- Older teenagers (18 to 20 years old) reduced provision of alcohol to other teens and the likelihood to try to buy alcohol or drink in a bar
- Significant decline in arrests for driving under the influence of alcohol among 18- to 20-year-olds

HOW IT WORKS

CMCA involves motivating community members to seek and achieve changes in local public policies and in the practices of community institutions that can affect youth's access to alcohol. CMCA offers resource materials to help communities organize these efforts, for example:

- Civic Groups can adopt policies to prevent underage drinking at organization-sponsored events and initiate and participate in community-wide efforts to prevent underage alcohol use.
- Faith Organizations can provide a link between prevention organizations, youth, parents, and the community. They can also offer education, develop internal policies to prevent teens from accessing alcohol at their events, and participate in efforts to keep alcohol away from youth.
- Schools can teach alcohol refusal skills and create and enforce policies restricting alcohol use and access, both on school property and in the surrounding community.
- Community Groups can voluntarily control the availability and use of alcohol at public events such as music concerts, street fairs, and sporting events.

PROGRAM BACKGROUND

The CMCA intervention was based on established research that showed the importance of the social and policy environment in facilitating or impeding drinking among youth. CMCA community organizing methods drew on a range of traditions in organizing efforts to deal with the social and health consequences of alcohol consumption.

IMPLEMENTATION ESSENTIALS

CMCA is a community-based program that can be implemented by a range of groups, from all-volunteer grassroots activists to nonprofit organizations or public agencies of any size. In order to successfully replicate CMCA, organizations need to be able to:

- Assess community norms, public and institutional policies, and resources
- Identify, from inception, a small group of passionate and committed citizens to lead efforts to advocate for change
- Create a core leadership group that can build a broad citizen movement to support policy change
- Develop and implement an action plan
- Build a mass support base
- Maintain an organization and institutionalize changes
- Evaluate changes on an ongoing basis
- Manage widely variable program costs

Community Trials Intervention to Reduce High-Risk Drinking (RHRD)

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PROVEN RESULTS

- Decreased alcohol sales to youth
- Increased enforcement of DUI laws
- Implementation and enforcement of RBS policies
- Adoption of policies limiting the dense placement of alcohol-selling establishments
- Increased coverage of alcohol-related issues in local news media

Community Trials Intervention to Reduce High-Risk Drinking (RHRD) is a multicomponent, community-based program developed to the alter alcohol use patterns of people of all ages (e.g., drinking and driving, underage drinking, acute (binge) drinking), and related problems. The program uses a set of environmental interventions including:

- Community awareness
- Responsible Beverage Service (RBS)
- Preventing underage alcohol access
- Enforcement
- Community mobilization

The program's aim is help communities reduce various types of alcohol-related accidents, violence, and resulting injuries.

PROGRAM BACKGROUND

The Community Trials Project was originally inspired by the success of community-wide programs to address chronic health problems such as cardiovascular disease, results from natural experiments (e.g., reductions in the minimum drinking age) and earlier community-wide programs designed to reduce drinking and drinking-related problems. Additionally, it involved a careful collection of baseline data during the pre-intervention period, adopted well-defined community-level alcohol-related problems as targets, had a long-term implementation and monitoring period, was followed by a final evaluation of changes in target problems, and involved an empirically-documented successful result in the target attributable to the intervention.

TARGET POPULATION

Each of the six interventions and comparison communities located in northern and southern California and South Carolina had approximately 100,000 residents. The communities were racially and ethnically diverse and included a mix of urban, suburban, and rural settings.

Target Areas

Protective Factors To Increase

Individual
- Perceived high risk of arrest for drinking and driving

Family
- Parental supervision of alcohol access to youth within the home

Community
- RBS training of alcohol establishments and related sales and service policies
- Enforcement of drinking and driving laws
- Publicity surrounding changes in youth alcohol access and drinking and driving enforcement
- Media advocacy in support of alcohol policy change
- Decreased alcohol outlet density
- Decreased formal and informal youth access to alcohol

Risk Factors To Decrease

Individual
- Low perceived risk of arrest for drinking and driving

Family
- In-home alcohol access to minors

Community
- Proliferation of alcohol outlets
- Alcohol sales and service to minors at on- and off-premise alcohol outlets
- Alcohol service to intoxicated patrons at bars and restaurants
- Lax enforcement of drinking and driving laws
- Little media coverage of community efforts to combat problematic drinking and associated outcomes

OUTCOMES
- 51% decline in self-reported driving when "over the legal limit" in the intervention communities relative to the comparison communities
- 6% decline in self-reported amounts consumed per drinking occasion
- 49% decline in self-reported "having had too much to drink"
- 10% reduction in nighttime injury crashes
- 6% reduction in crashes in which the driver had been drinking
- 43% reduction in assault injuries observed in emergency rooms
- 2% reduction in hospitalized assault injuries

BENEFITS
The program brings about:
- Reductions in intentional and unintentional alcohol-related injuries (i.e., car and household accidents, assaults)
- Mobilization of community members and key policy makers
- Increased enforcement of drinking and driving laws
- Decreased formal and informal youth access to alcohol
- Responsible alcohol beverage service and sales policies

HOW IT WORKS
For the RHRD program to be successful, the implementing organization must first determine which program components will best produce the desired results for its community. The RHRD program uses five prevention components, including:

- Alcohol Access
- Responsible Beverage Service
- Risk of Drinking and Driving
- Underage Alcohol Access
- Community Mobilization

IMPLEMENTATION ESSENTIALS
Understanding the community's alcohol environment (e.g., norms, attitudes, usage locations, cultural and socioeconomic dynamics, etc.) and alcohol distribution systems (e.g., alcohol sales licensing, alcohol outlet zoning, and alcohol use restrictions) are key to the startup of RHRD. This requires gathering the data needed to determine which interventions to use and adapting them to the individual community.

Project staff are key to this information-gathering and for working with a wide array of community components, including local community organizations, key opinion leaders, police, zoning and planning commissions, policymakers and the general public. Though dependent on local conditions, staff generally includes a Director, Assistant director, Data managers, Administrative, Volunteers, and Program Task Force. Staff can be employees of the lead agency endeavoring to implement the program or may be hired and separate from existing entities.

Training & Materials
Training and consultation target the specific needs and problems of the individual community. Consultation is available and is tailored to the individual site. Training manuals for RBS are available at a minimal cost.

Creating Lasting Family Connections (CLFC)

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PROVEN RESULTS*

- Delayed onset of substance use for participating youth
- Decreased use of substances among participating youth
- Increased parents' knowledge and appropriate beliefs about substance use
- Increased parental involvement in setting rules about substance use

* Compared to non-participants.

Creating Lasting Family Connections (CLFC) is a comprehensive family strengthening, substance abuse, and violence prevention curriculum. CLFC has demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy, and supportive people. Program results, documented with children 11 to 15 years old, have shown significant increases in children's resistance to the onset of substance use and reduction in use of alcohol and other drugs. CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.

PROGRAM BACKGROUND

CLFC is the national dissemination model based on the results of Creating Lasting Connections (CLC), a 5-year Center for Substance Abuse Prevention (CSAP) research demonstration project. The project was designed as an ecumenical, community-based program focused on increasing community, family, and individual youth protective factors that would delay the onset and reduce the frequency of substance use. The program was delivered to at-risk 11- to 15-year old youth through the implementation of a pre-existing and privately developed prototype version of CLFC. The external evaluation of the CLC program showed that the program increased key resiliency factors and (through moderating effects) delayed the onset of substance use and reduced the amount of use.

TARGET POPULATION

CLFC is designed for youth 9 to 17 years old and their families. The populations that participated in the evaluations were primarily African American, Caucasian, or of mixed ethnicity; were 11 to 15 years of age; and lived in rural, suburban, or urban settings. The program has been implemented in 40 States with a variety of populations including Hispanic, Asian American, and Native American. CLFC has been successfully implemented in schools, faith communities, recreation centers, community settings, juvenile justice facilities, and other settings.

OUTCOMES

The CLFC program evaluation found positive effects on family and youth resiliency and on substance use among youth 11 through 15 years of age. The program also increased community resiliency by empowering community volunteers to identify, recruit, and retain families.

Statistically significant overall program effects on family resiliency included:

- Improved parental knowledge of and beliefs about substance use
- Increased youth involvement in setting rules related to substance use
- Increased use of community services

Target Areas

Protective Factors To Increase

Individual
- Appropriate substance use knowledge and beliefs
- Attitudes unfavorable to substance use
- Refusal skills
- Bonding with mother and father
- Honest communication
- Participation in family rule setting
- Bonding with community
- Social skills

Family
- Appropriate parental substance use knowledge and beliefs
- Appropriate parental substance using behavior
- Family management skills (including family meetings)
- Bonding with youth
- Involvement of youth in family rule setting (both substance related and not)
- Help-seeking for family and personal problems
- Appropriate expectations and consequences
- Family stability, harmony, cohesiveness, and positive communication
- Family recreational and community activities

School
- School bonding by youth
- School attendance
- Positive school climate

Community
- Youth and parent perceptions of community support
- Access to health and social service
- Community empowerment
- Responsiveness and flexibility of social service provision
- Community service

Risk Factors To Decrease

Not Applicable

Positive effects on youth resiliency included:
- Increased use of community services when personal or family problems arose
- Increased bonding with mother, father, and siblings
- Increased community involvement under specific conditions

In addition, the program improved family modeling of alcohol use in African-American communities and moderated overall family alcohol use. Most important, the evaluation found that reductions in substance use among youth who participated in the program were conditionally related to changes in family-level and youth-level resiliency factors targeted by the program.

BENEFITS

CLFC is designed to:
- Improve refusal skills, resulting in both delayed onset and reduced use of substances by youth
- Increase communication and bonding between parents and children
- Foster greater use of community services in resolving family and personal problems
- Decrease uncontrolled behavior (i.e., reduce violence

HOW IT WORKS

Implementing the CLFC model involves:
- Identifying, recruiting, assessing, and selecting the community system(s) that will serve as the focal point of the program
- Creating, orientating, and training a small cadre of community volunteers to advocate for youth in high-risk environments and their families, and recruiting and helping retain those families in the program
- Recruiting youth and families from high-risk environments
- Administering six highly interactive training modules, three each to both parents and youth, separately (i.e., one module on substance use issues, a second on personal and family responsibilities, and a third on communication and refusal skills)
- Providing early intervention services and followup services

IMPLEMENTATION ESSENTIALS

For a high fidelity replication of CLFC, at least two part-time facilitators are needed for each of the parent and youth modules. After the recruitment phase, these four part-time facilitators can work with up to 30 families, 1 day per week, 4 hours a day, for the duration of the 20-week program. A minimum of two facilitators for each group is strongly recommended because a team approach significantly enhances the group learning experience and is likely to increase the participants' positive response to the program.

Program start-up takes 1 to 3 months, and includes: 5 to 10 days of training by the developer, community mobilization activities, and identification and recruitment of parents and youth

Facilitators should provide 2.5 hour parent and youth training sessions weekly, over a 20-week period. The modules may also be offered in 5-week increments throughout the year if families are unable to commit to a 20-week program. Facilitators are also responsible for case management or referrals to community services (an optional element when used with universal populations).

DARE To Be You (DTBY)

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PROVEN RESULTS*

- Increased parental effectiveness and satisfaction, maintained over 2 years*
- Increased appropriate parental limit setting, maintained for 2 years
- Decreased parental child blaming and harsh punishment
- Increased child developmental level, maintained for at least 2 years*

* Compared to control group..

DARE To Be You (DTBY) is a multilevel, primary prevention program for children 2 to 5 years old and their families. It significantly lowers the risk of future substance abuse and other high-risk activities by dramatically improving parent and child protective factors in the areas of communication, problem solving, self-esteem, and family skills. Program interventions are designed to:

- Improve parents'sense of competence and satisfaction with being a parent
- Provide parents with knowledge and understanding of appropriate child management strategies
- Improve parents'and children's relationships with their families and peers
- Boost children's developmental levels

DTBY program materials are available in English and Spanish.

PROGRAM BACKGROUND

The DARE To Be You program began in 1979 with a research grant from the Centers for Disease Control (CDC) to establish a community-based system to help decrease alcohol and tobacco use by youth 8 to 12 years old. In 1985, the U.S. Department of Education funded a K-12 curriculum and corresponding teacher training. In 1989, the Center for Substance Abuse (CSAP) funded the development and evaluation of the component for families and their preschool youth described in this fact sheet. A 2-year project developed, and the DTBY principles were tested with these youth as they became 10 to 14 years of age. Because of the positive results of this research, the Colorado Department of Health, for 14 years, included DTBY in its community team prevention efforts. Requests from both researchers and community teams led to development of the teacher training/school component and the family component.

TARGET POPULATION

The original participants were Native American, Hispanic, African American, and Caucasian parents and their preschool children at locations across Colorado. Additional participants included siblings, Head Start teachers, day care personnel, and other supportive community members who worked with the families. Positive results held true for all sites and ethnic groups.

OUTCOMES

- Significantly increased satisfaction with support systems and self-sufficiency
- Better child self-management and family communication reported by families.
- 45 percent of the families had a male father figure participate and complete the intervention

BENEFITS

- Improved parental competence

Target Areas

Protective Factors To Increase

Individual
- Positive personal characteristics (e.g., social and communication skills)
- Positive sense of self (e.g., competence and efficacy)
- Problem-solving skills
- Internal locus of control
- Empathy
- Autonomy
- Future orientation
- Appropriate developmental attainments and school readiness
- Enhanced socioeconomic status (through increased self-efficacy and motivation)

Family
- Nurturing and well managed home environment
- Attachment to parents and extended family
- Parental satisfaction with parental role
- Positive parent-child interactions

Risk Factors To Decrease

Individual
- Low parental effectiveness and satisfaction
- Poor school readiness for children entering school (low developmental level)
- Poor self-management skills
- Economically disadvantaged
- Individual mental health problems

Family
- Disorganized or unstable family environment
- Poor communication
- Child or self-blame attributions leading to potential abuse
- Family mental health problems

Community
- High levels of alcohol and drug abuse
- Pro alcohol and drug use norms

- Increased satisfaction with and positive attitude about being a parent
- Adoption and use of nurturing family management strategies
- Increased and appropriate use of limit setting
- Substantial decreases in parental use of harsh punishment
- Significant increases in child developmental levels

HOW IT WORKS

The DARE To Be You program should have a site sponsor—a key agency that works with families. While the site sponsor may vary with the needs of the community, it must be respected by the community. Sponsors may be Head Start or other preschool educational programs, schools, family centers or coalition groups. The program is delivered to families at a site convenient to the families in a location comfortable for families to attend. The program consists of three components:

- Family Component, which offers parent, youth, and family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills. It consists of an initial 12-week family workshop series (30 hours) and semiannual 12-hour reinforcing family workshops. (Post-DTBY support groups are also recommended.)
- School Component, which trains and supports teachers and child care providers who work with the target youth.
- Community Component, which trains community members who interact with target families, local health departments, social service agencies, family center personnel, probation officers, and counselors.

IMPLEMENTATION ESSENTIALS

For the Family Component, DTBY activities require a room large enough to handle up to 45 family members and staff, two or more breakout rooms for 20 to 30 children, and space for the family meal. One medium-size room is needed for teacher and community member training.

A positive and nurturing staff of three part-time professionals is required to effectively deliver DTBY to 20 adult family members and their children (per session), including: a site coordinator, a parent trainer/facilitator, and a child program coordinator/teen trainer-supervisor

Teen Teachers are recruited to work with the program children 3 hours a week. Two to five hours of clerical/administrative support will be needed.

Evaluation Staff is required by research design.

Training and Materials

Three days (20 hours) of on-site implementation training for up to 35 site team members, plus 2 hours of technical assistance (TA) by telephone is available from DTBY staff. Followup implementation/site visits (one-day minimum) and other TA packages are also available.

Early Risers: Skills for Success

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PROVEN RESULTS*

- Signigficant gains in social competence including improved social skills and social adaptability
- Significant gains in academic achievement
- Children with the most severe aggressive behavior showed significant reductions in self-regulation problems
- Children whose parents achieved recommended levels of participation reported less parental distress and improved methods for disciplining children

* Relative to comparisons.Different tests focus on changes over time between program and control.

Early Risers is a multicomponent, high intensity, competency enhancement program that targets elementary school children 6 to 10 years old who are at high risk for early development of conduct problems, including substance use. Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses a full strength intervention model with two complementary components to move high-risk children onto a more adaptive developmental pathway. Interventions include:

- Child social skills training and strategic peer involvement
- Reading and math instruction and educational enrichment activities
- Parent education and skills training
- Family support, consultation, and brief interventions to cope with stress
- Proactive parent-school consultation
- Contingency management of aggressive, disruptive, and noncompliant behavior

The enhanced competence gained through Early Risers program leads to the development of positive self-image, independent decisionmaking, healthy problem solving, assertive communication, and constructive coping. Once acquired, these attributes and skills collectively enable youth to resist personal and social forces that encourage early substance use and potential abuse and dependency.

PROGRAM BACKGROUND

Over a 10-year period, Early Risers evolved from a school-based intervention delivered by teachers and expert consultants to a community-based intervention delivered by community providers. Its home visitation delivery system provides for interventions and services that are tailored to each family's strengths, needs, and barriers to participation. Several variations of the program now exist; each contextualized to accommodate both urban and rural implementation.

TARGET POPULATION

Early Risers is a prevention program for children ages 6 to 10 years of age and their families. Original participants were primarily Caucasian and resided in semi-rural communities. Subsequent replications of the program have involved African-American children and their families living in economically disadvantaged urban communities. The program is specifically aimed at children who display early aggressive, disruptive, and/or nonconformist behaviors.

OUTCOMES

High risk children whose parents received 50 percent or more of recommended FLEX home visiting contact time showed higher rates of improvement on academic achievement, lower rates of attention/concentration problems, and greater rates of improvement in social skills and overall social competence.

Target Areas

Protective Factors To Increase

Individual
- Emotional regulation and behavior control skills
- Prosocial behavior
- Interpersonal communication skills
- Social problem-solving skills
- Conflict resolution and anger management skills
- Positive attitudes toward school
- Reading, written expression, and math skills
- Affiliation with prosocial peers

Family
- Parenting self-efficacy
- Empowerment
- Personal well-being
- Involvement in community alliances
- Access to community systems of care
- Supportive and nurturing parental behavior

School
- Supportive and competent teachers
- Supportive schools

Risk Factors To Decrease

Individual
- Early aggressive and disruptive behavior
- Poor academic achievement
- Damaged peer relationships
- High emotional reactivity or impaired emotional regulation

Family
- Limited community support systems
- Inconsistent or ineffective discipline methods
- Low monitoring and supervision
- Harsh and disapproving communication
- Low support and involvement
- Limited educational stimulation and support for mastery
- Parent mental illness and substance abuse
- Social insularity and martial discord
- Poverty and unemployment

BENEFITS
- Positive self-image
- Self-regulation and constructive coping
- Healthy problem-solving and assertive communication skills
- Positive peer affiliations
- Positive attitudes toward learning
- Parental competence and capacity to support and nurture children's development

HOW IT WORKS
A Family Advocate is responsible for running Early Risers. This individual coordinates and provides services for the CORE (child-focused) and FLEX (parent/family-focused) components. The Family Advocate is responsible for delivering Early Riser's manualized program to children and their parents, year-round, at school and at home. Early Risers is best implemented in schools or local community centers. ASummer Program component is ideally delivered in community school settings, but can also be run in community centers, faith-based centers, or similar locations. The Summer Program also requires a larger staff.

IMPLEMENTATION ESSENTIALS
Staffing

Cost-effective operation of Early Risers requires one Family Advocate for every 25 to 30 child/family participants. A qualified Family Advocate must have a minimum of 2 years of field experience in human services and a bachelor's degree in social work or related field. A supervisor, responsible for staff recruitment, education, training, oversight, and evaluation is also needed.

Program Training and Materials

A 5-day training program can be held at the host site for up to 20 family advocates and program supervisors. Further technical assistance via site visits or phone contact is recommended. Early Risers offers a Skills for Success Training Manual, Skills for Success Program Video, and other program resources.

Timeline
- Start up activities including screening and recruiting children and their families, recruiting and training program family advocates, developing referral sources and relationships with community service providers, and obtaining school support will require 3 to 6 months.
- Program implementation starts with a 6-week Summer Program that runs 4 days per week.
- The Check and Connect Program begins shortly after the start of the school year and runs concurrently until the end of each school year for 2 to 3 years.
- The Family Program also begins shortly after the start of the school year. Parent and child groups are assembled and meet for biweekly evening sessions (12 sessions in years 1 and 2 and six sessions in year 3). Sessions begin with a communal family dinner followed by concurrent parent and child groups that last approximately 90 minutes, and concluding with a 30-minute parent-child interactive activity.
- FLEX family support program begins approximately 3 months into the school year and runs continuously thereafter. The amount of FLEX contact time will vary for each family based on need. A minimum of six home visits per year is recommended.

Family Effectiveness Training (FET)

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PROVEN RESULTS

- 35% reduction in children's conduct problems
- 66% reduction in children's associations with antisocial peers
- 34% reduction in children's irresponsible behaviors
- 14% improvement in children's self-concept
- 75% improvement in family functioning

Family Effectiveness Training (FET) is a family-based program developed for and targeted to Hispanics. It is effective in reducing risk factors and increasing protective factors for adolescent substance abuse and related disruptive behaviors. FET, applied in the pre-adolescent years (6 to 12), targets three family factors that place children at risk as they make the transition to adolescence: 1) problems in family functioning, 2) parentñchild conflicts, and 3) cultural conflicts between children and parents.

FET uses two primary strategies:

1. Didactic lessons and participatory activities that help parents master effective family management skills
2. Planned family discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members

Interventions employed by FET cover:

- Normal family changes during the transition to adolescence and related conflict resolution
- Substance use and adolescent alternatives to using
- Parent and family supervision of children and their peer relationships
- Family communication and parenting skills

PROGRAM BACKGROUND

FET grew out of a long-standing tradition of work with Hispanic immigrant families at the Spanish Family Guidance Center in the University of Miami Center for Family Studies. The current version of FET was developed to work with families of pre-adolescents to foster parenting skills needed in American society before children had grown old enough to manifest the cultural gaps associated with problem behavior and drug abuse in Hispanic immigrant families.

TARGET POPULATION

FET helps Hispanic immigrant families with 6- to 12-year old children, particularly in cases where the child is exhibiting behavior problems, associating with deviant peers, or experiencing parent-child communication problems. Program evaluation has only been conducted with Hispanic families.

OUTCOMES

FET reduced children's conduct problems, promoted maturity and reduced personality problems, and improved children's self-concept. FET was also shown to improve family functioning.

Target Areas

Protective Factors To Increase

Individual
- Bicultural adjustment
- Acceptance of culture of origin
- Self-discipline
- Positive transition into adolescence
- Alternatives to drug use
- Good self-concept
- Conventional beliefs and attitudes
- Good school attendance, conduct, and achievement

Family
- Family bicultural adjustment
- Understanding of family development
- Effective parent-child communication
- Family conflict resolution skills
- Effective parental nurturance and behavior control
- Increased family cohesiveness
- Effective parenting skills in managing child's peer relations

Risk Factors To Decrease

Individual
- Cultural identity confusion
- Rejection of culture of origin
- Behavior problems in school or at home
- Early antisocial behavior
- Association with antisocial peers
- Feelings of inadequacy and immaturity
- Poor self-discipline
- Poor frustration tolerance
- Poor self-concept
- Unconventional beliefs or attitudes

Family
- Poor parent-child communication
- Parent-child conflict
- Parent-child cultural conflict
- Negative effect in family interactions
- Marital problems
- Family isolation
- Ineffective parental behavior control
- Parent uninvolved with child, child's school, and child's peers

BENEFITS

- Improves parental understanding of their children's cultural assimilation, and children's understanding of their parents'Hispanic culture, bridging the culture gap between parents and children
- Improves family cohesiveness and child bonding to the family
- Improves parental knowledge, understanding, competence, and skills to effectively manage children's behavior
- Increases parental and child knowledge about, and negative attitudes toward, substance use
- Increases substance use resistance skills in children
- Improves child self-discipline and self-concept
- Reduces child antisocial and immature behavior

HOW IT WORKS

FET is designed to engage and retain a family in the program by focusing on the way the entire family functions and viewing the child's problems as a symptom of cultural differences within the family.

During the course of 13 family sessions, FET uses the following strategic interventions:

- Teaching bicultural skills to promote bicultural effectiveness
- Providing Brief Strategic Family Therapy (BSFT), a problem-focused, direction-oriented, and practical approach to the elimination of substance abuse risk factors
- Educating parents on normal adolescent development
- Promoting effective parenting skills
- Promoting family communication, conflict resolution, and problem solving skills
- Disseminating substance abuse information to parents

IMPLEMENTATION ESSENTIALS

FET requires committed, enthusiastic, sympathetic counselors who are familiar with and respectful toward Hispanic and American cultures, language, and values. Each family participates in the program for 13 weeks, with one 1.5- to 2-hour session per week. One full-time counselor can provide FET to 15 to 20 families per week, depending on the experience and maturity of the counselor.

Agencies should allow 6 months to hire and train counselors, develop referral resources from the community, and recruit and screen participant families. The provider agency must be open at times convenient to families, and provide transportation and childcare when needed.Videotaping equipment, a monitor, and a VCR are needed for supervision and review of work. Midsize offices with a blackboard or easel are adequate for administering FET and videotaping sessions. Finally, visual teaching aids and handouts for families are required.

Training and Support

Training for FET is offered in both English and Spanish and is available onsite for agencies located in North America. Each training workshop can accommodate up to 12 counselors. Each trainee receives a copy of all FET materials, including lesson plans, charts, and the FET manual. Technical assistance is available by phone or in person. Assistance includes evaluation and supervisory feedback on videotaped FET sessions reviewed by the training faculty.

Incredible Years Training Series

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PROVEN RESULTS

- According to standardized reports by teachers and parents, at least 66% of children previously diagnosed with Oppositional Defiant Disorder/Conduct Disorder (ODD/CD) whose parents received the parenting program were in the normal range at both the 1-year and 3-year followup assessments
- The addition of the teacher and/or child training programs significantly enhanced the effects of parent training, resulting in significant improvements in peer interactions and behavior at school.

The Incredible Years Training Series features three comprehensive, multi-faceted, and developmentally based curricula for parents, teachers, and children. The program is designed to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children (2 to 8 years old).

Young children with high rates of aggressive behavioral problems have been shown to be at great risk for developing substance abuse problems, becoming involved with deviant peer groups, dropping out of school, and engaging in delinquency and violence. Ultimately the aim of the teacher, parent, and child training programs is to prevent and reduce the occurrence of aggressive and oppositional behavior, thus reducing the chance of developing later delinquent behaviors.

Incredible Years addresses multiple risk factors known to be related to the development of conduct disorders in children in both school and home. In all three training programs, trained facilitators use videotaped scenes to structure the content and stimulate group discussion and problem solving.

PROGRAM BACKGROUND

The Incredible Years series was developed to promote positive, effective, and research-proven parenting and teaching practices that strengthen young children's social competence and problem-solving abilities, and reduce aggression at home and school. In the 1980s, the BASIC parenting program was evaluated and found to be very successful in promoting lasting improvements in parent-child interactions and reducing children's behavior problems at home for at least two-thirds of the children. However, a followup evaluation 3 years later indicated that approximately one-third of the children were still having considerable difficulties at school and with their peer group. As a result of these findings, two new components—one focusing on parental communication, anger management, and problem-solving skills (ADVANCE) and another that developed child social skills, and promoted problem-solving strategies and emotional language (Dinosaur School)—were added. Evaluation indicated these program components enhanced peer relationships, social problem-solving, and marital collaboration.

TARGET POPULATION

Incredible Years has been tested with 2- to 8-year-old children presenting with conduct problems (i.e., having high rates of aggression, defiance, oppositional and impulsive behaviors). It has also been evaluated with children 2 to 6 years old, who are at high risk by virtue of living in poverty. These programs have been evaluated and found successful with children of both genders from various ethnic groups, including Hispanic, Asian American, and African American, and diverse socioeconomic backgrounds in parts of the United States, Canada, and Great Britain.

Target Areas

Protective Factors To Increase

Individual
- Child social competence
- Positive interactions with peers
- Social skills

Peer
- Positive peer play

Family
- Nurturing family atmosphere
- Strong parent-child bonds
- Family support
- Parenting skills

School
- Cooperation with teachers and peers
- Problem solving abilities
- Academic success
- Teacher classroom management

Community
- Community support
- Positive networks with other families
- Increased community involvement with school

Risk Factors To Decrease

Individual
- Problems with aggressive behavior
- Harsh, critical parenting behaviors
- Corporal punishment

Peer
- Peer rejection
- Aggression towards peers

School
- Negative classroom atmosphere
- Poor classroom management
- Child aggression at school
- Overly critical teacher behaviors

Family
- Rejecting, unsupportive family atmosphere
- Poor parent–child bonds

OUTCOMES

Two randomized control group evaluations indicated that the child training series significantly:

- Increased children's appropriate cognitive problem-solving strategies
- Increased children's use of prosocial conflict management strategies with peers
- Increased children's social competence and appropriate play skills
- Reduced conduct problems at home and school

BENEFITS

- The child program promotes children's social competence and reduces conduct problems
- The parent program helps parents strengthen parenting skills and become more involved in their children's school activities
- The teachers'program strengthens their classroom management skills, reduces classroom aggression, and improves teachers'ability to focus on students'social, emotional, and academic competence

HOW IT WORKS

The program uses interventions delivered through three curricula: BASIC (basic parenting skills), ADVANCE (parental communication and anger management) and SCHOOL (parents promoting children's academic skills), which are presented in four distinct formats: (1) Dina Dinosaur Small Group Therapy: 18 to 22, 2-hour weekly sessions for children; (2) Dina Dinosaur Classroom: Includes 60 lesson plans that can be delivered one to three times a week in 45-minute class periods (preschool and early school-age lesson plans available); (3) Parenting Groups; and (4) Teacher Classroom Management Series

IMPLEMENTATION ESSENTIALS

To successfully implement the Incredible Years program, the organization or school must be committed to excellence, evident in good administrative support and support for facilitator certification by certified trainers, as well as ongoing technical support and consultant workshops.

It is recommend that each group has two group leaders. Group leaders complete a certification process that involves attendance at a certified training workshop, peer review, videotape feedback, and consultation.

Training and Materials

Certified trainers are available to train therapists, counselors, teachers, and others to run parent, teacher, and child groups. Training sessions can accommodate 25 people, and run 3 days for group leaders of the Parenting Program, 2 days for leaders of the Dinosaur Child Program, and 4 days for the teacher Classroom Management Program.

Keep A Clear Mind (KACM)

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Keep A Clear Mind (KACM) is a take-home drug education program for upper elementary school students (8 to 12 years old) and their parents. The take-home material consists of 4 weekly sets of activities to be completed by parents and their children together. The program also uses parent newsletters and incentives.

KACM lessons are based on a social skills training model and designed to help children develop specific skills to refuse and avoid the use of "gateway" drugs. This unique, early intervention program has been shown to positively influence known risk factors for later substance use.

PROVEN RESULTS*

As a result of participation, students were:

- Less likely to expect to use cigarettes or snuff
- More likely to indicate an increased confidence in their ability to resist pressure to use tobacco
- More likely to have changed their viw of peer use of tobacco, alcohol, and marijuana (i.e., they viewed use as less common)
- More likely to realize the harmful effects of tobacco

* Compared to students not in the program.

PROGRAM BACKGROUND

KACM was developed to provide schools with a program that did not require extensive classroom interventions, created parental involvement, was easy and inexpensive to implement, and addressed known risk factors for substance use. The program is based largely on social-cognitive theory and behavioral self-control theory. Program development was initially funded by the U.S. Department of Education with additional funds coming from the Nancy Reagan Foundation and the Community Care Foundation.

TARGET POPULATION

KACM is designed for upper elementary school students and their families. The program has been rigorously evaluated in field tests involving students in grades four through six and their parents.

OUTCOMES

Findings generated from the evaluation of KACM activities have considerable scientific and programmatic significance for substance use prevention in youth. Outcomes reported by parents who participated in the program (compared to those in the control group) include:

- 20% more parents indicated that their children had an increased ability to resist peer pressure to use alcohol, tobacco, and marijuana
- 29% more parents indicated a decreased expectation that their children would try substances
- 14% more parents expressed a more realistic view of drug use among young people and a greater realization of its effects

Target Areas

Protective Factors To Increase

Individual
- Problem-solving skills
- Communication and social skills
- Belief in society's values
- Motivation to purse positive goals
- Accurate perception of social norms

Family
- High parental expectations
- Clear and consistent parental expectations
- Parental involvement

Society
- Media literacy and resistance to pro-use messages

Risk Factors To Decrease

Individual
- Lack of self-control and peer refusal skills
- Favorable attitudes toward use
- Low self-confidence in ability to refuse alcohol offers

Peer
- Susceptibility to negative peer pressure

Family
- Family attitudes that favor substance use
- Ambiguous, lax, or inconsistent rules regarding use

BENEFITS

- Increases student ability to resist peer pressure to use tobacco, alcohol, and marijuana
- Increases student recognition of the harmful effects of tobacco, alcohol, and marijuana
- Helps students identify and choose positive alternatives to substance use
- Decreases students' actual use of tobacco, alcohol, and marijuana
- Helps parents to become effective drug educators
- Increases parent-child communication about substance use

HOW IT WORKS

KACM consists of:

- Four take-home lessons on tobacco, alcohol, marijuana, and drug refusal
- Five parent newsletters
- Student incentives

KACM requires a minimal commitment of organizational time, yet it is a cost-effective way to reach parents and enhance parent-child communication about substance use. The program can be easily facilitated by schools, youth organizations, religious groups, and health centers.

IMPLEMENTATION ESSENTIALS

KACM is easy to implement. The program is usually conducted over the course of one semester during a school year or during a similar time period. Successful replication of KACM involves:

- Recruiting fourth, fifth, and/or sixth grade students to participate in the program
- Recruiting a program facilitator (e.g., classroom teacher, counselor, etc.)
- Delivering lessons and newsletters, and monitoring the implementation of take-home lessons
- Conducting pre- and post-program outcome data collection to measure program effects

Program facilitator training is helpful, but is not essential to the delivery of the program. Many schools find that KACM t-shirts are a useful incentive, but they are also not essential. Assistance in analyzing outcome data and developing evaluation reports is available.

Leadership and Resiliency Program (LRP)

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PROVEN RESULTS*

- Significant reduction in school absences over previous years
- Grade point averages increased 0.8 (on a 4.0 scale)
- Increased sense of school bonding
- Extremely high percentage of participants either become employed or pursue post-secondary education; 100% graduated

The Leadership and Resiliency Program (LRP) is a school- and community-based program for high school students (14 to 19 years of age) that works to enhance youths' internal strengths and resiliency, while preventing involvement in substance use and violence. Program components include:

- Resiliency Groups held at least weekly during the school day
- Alternative Adventure Activities that include ropes courses, white water kayaking, camping, and hiking trips
- Community Service in which participants are active in a number of community- and school-focused projects

These alternative activities, offered after school, on weekends, and during the summer, focus on community service, altruism, learning about managed risk, social skills improvement, and conflict resolution.

PROGRAM BACKGROUND

LRP is the result of grass roots advocacy for vital youth substance abuse prevention and youth development services. Local faith and community groups believed collaborative, cost-effective, and innovative programming was the best way to engage youth in positive activities and thus prevent substance use. These groups turned to Fairfax County (VA) Alcohol and Drug Services (ADS) with their ideas. ADS prepared a successful grant proposal that funded the development of LRP.

The Washington/Baltimore HIDTA (High Intensity Drug Trafficking Area) of the Office of National Drug Control Policy, funded ADS to run LRP as a 3-year regional demonstration project. The University of Maryland provided research oversight. LRP continues to be funded and operated by the Fairfax-Falls Church Community Services Board, a Fairfax County, Virginia agency, in cooperation with Fairfax County Public Schools.

TARGET POPULATION

LRP is a year-round, comprehensive program aimed at youth ages 14 to 19, who have a combination of behavioral issues manifested in high absence and disciplinary rates, low grades, substance use, and/or violence. School administrators and guidance staff, in cooperation with prevention staff from a collaborating community agency, identify participants; however, some students self-nominate. Students are interviewed to assess their risk and protective factors and the highest risk students are enrolled in the program. Study participants have been from diverse cultural and ethnic backgrounds, and the program is designed for both mainstream and alternative high school populations.

Target Areas

Protective Factors To Increase

Individual
- Empathy
- Optimism
- Social and emotional competence
- Bonding to societal institutions and values
- Positive personal characteristics
- Future orientation

Peer
- Association with healthy, positive peer group
- Peer refusal skills
- Healthy peer boundaries

Family
- Identification of values

School
- School bonding and involvement
- High expectations from school personnel

Risk Factors To Decrease

Individual
- Favorable attitudes towards substance use
- Conduct problems
- Strong, external locus of control
- High sensation-seeking behaviors
- Emergent mental health concerns

Peer
- Substance use in peer group
- Association with delinquent peers
- Negative peer pressure

School
- Academic failure
- Poor student morale

OUTCOMES

Program participants realized:
- An increase of 0.8 in GPA (based on a 4.0 scale)
- A 60% to 70% increase in school attendance
- A 65% to 70% reduction in school behavioral incidents
- 100% graduation rates

BENEFITS

The program is designed to:
- Increase students'perceptions of competence and self-worth
- Improve participant identification with positive roles
- Reduce disciplinary actions in school
- Improve participants'communication and refusal skills
- Increase knowledge of and negative attitudes about substance abuse and violence
- Increase community involvement in promoting the healthy development of youth and the valuing of adolescents

HOW ITWORKS

LRP requires a partnership between a high school and a substance abuse or health service agency. Schools work with agency personnel to identify program candidates and provide different types of support, as needed. For best results, students should enter the program early in their high school career and participate until graduation. Participants attend weekly in-school resiliency groups lead by a facilitator (i.e., program leader) for the duration of the program. Additional individual or small group followup discussions between the facilitator and students may be held at other times during the week. LRP students are expected to participate at least weekly in community service activities, which take place after school or on weekends.

IMPLEMENTATION ESSENTIALS

Cooperative agreements must be set up between the school where the program will be implemented and the substance abuse treatment or health service provider, as well as with a humane foundations (i.e., animal shelters), contractors for outdoor activities, volunteer groups or businesses that can provide space for summer activities, and the elementary schools where the students will deliver their puppet projects. Ongoing communication to coordinate these activities is also needed.

In order to staff the program, schools will need to hire:
- Program Leaders who work directly with students and are able to effectively manage a caseload of 50 youth.
- A Program Supervisor/Manager who will handle project management, data collection, and outcomes analysis.

Program start-up, which includes hiring and training staff—as well as identifying and establishing agreements and partnerships with schools, businesses, and off-site programming—can take up to 4 months. Implementation requires that youth participate in all three program components over the course of 5 months to 1 year for each of the 2 to 4 years they are in the program. (Four years of programming is possible for participants who enter LRP in their freshman year.)

LifeSkills™ Training

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LifeSkills™ Training (LST) is a program that seeks to influence major social and psychological factors that promote the initiation and early use of substances. LifeSkills has distinct elementary (8 to 11 years old) and middle school (11 to 14 years old) curricula that are delivered in a series of classroom sessions over 3 years. The sessions use lecture, discussion, coaching, and practice to enhance students'self-esteem, feelings of self-efficacy, ability to make decisions, and ability to resist peer and media pressure.

PROVEN RESULTS*

These effects have been observed up to 6 years after the intervention:

- Alcohol, tobacco, and marijuana use cut 50% to 75%
- Multiple drug use decreased up to 66%
- Pack-a-day smoking reduced by 25%
- Decreased use of inhalants, narcotics, and hallucinogens

* Outcomes relative to controls.

LifeSkills consists of three major components that address critical domains found to promote substance use.The three components each focus on a different set of skills:

- Drug Resistance Skills enable young people to recognize and challenge common misconceptions about substance use, as well as deal with peers and media pressure to engage in substance use.
- Personal Self-Management Skills help students to examine their self-image and its effects on behavior, set goals and keep track of personal progress, identify every day decisions and how they may be influenced by others, analyze problem situations, and consider the consequences of alternative solutions before making decisions.
- General Social Skills give students the necessary skills to overcome shyness, communicate effectively and avoid misunderstandings, use both verbal and nonverbal assertiveness skills to make or refuse requests, and recognize that they have choices other than aggression or passivity when faced with tough situations.

PROGRAM BACKGROUND

Beginning in the 1980s, a series of evaluation studies have been conducted to test the effectiveness of substance abuse prevention approaches based on the LifeSkills model. These studies have helped to facilitate the development of a prevention approach that is effective with different problem behaviors when implemented by different types of providers, and with different populations.

The focus of the early research was on cigarette smoking and involved predominately Caucasian, middle-class populations. More recent research extended this work to other problem behaviors including substance use. In addition, this research has increasingly focused on the utility of this approach when used with inner-city, minority populations. Finally, this research has assessed the long-term durability of the LifeSkills Training prevention model, its impact on hypothesized mediating variable, and the importance of high fidelity implementation.

TARGET POPULATION

LifeSkills Training targets individuals who have not yet initiated substance use. It is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The program has been tested in urban and suburban schools with Caucasian, African- American, Hispanic,

Target Areas

PROTECTIVE FACTORS TO INCREASE

Individual
- Social development, self-esteem, self-discipline
- Communication skills
- Decisionmaking skills
- Problem solving skills
- ocial skills
- Assertiveness and refusal skills
- Stress and anxiety management
- Goal setting, self-monitoring, self-reinforcement

Peer
- Resistance to peer pressure
- Social skills

Family
- Effective communication with parents and other family members

School
- Academic success
- Goal setting

RISK FACTORS TO DECREASE

Individual
- First confrontation with illegal substances, tobacco, and alcohol
- Lack of self-control and assertiveness

Peer
- Prodrug influences

and Asian-American students in grades 7 through 12 (11 to 18 years old). An elementary school version of LifeSkills has been tested with students in grades 3 to 5 (8 to 11 years old).

OUTCOMES

- Reduced initiation of cigarette smoking by 75%, and 3 months after program completion, by 67%
- Reduced alcohol use by 54%, heavy drinking by 73%, and drinking to intoxication one or more times a week by 79%
- Reduced marijuana use by 71%, and weekly or more frequent use by 83%
- Reduced multiple drug use by 66%
- Reduced both long-term and short-term substance abuse
- Reduced pack-a-day smoking by 25%
- Decreased use of inhalants, narcotics, and hallucinogens by up to 50%

BENEFITS

- Develops resistance to peer and media pressure to use substances
- Develops a positive self-image
- Develops decisionmaking and problem-solving skills
- Helps youth manage anxiety
- Fosters effective communication
- Builds healthy relationships
- Increases youths' self-confidence in social situations

HOW IT WORKS

The LifeSkills Training curriculum for middle (or junior high) schools is intended to run for fifteen 45-minute class periods. A booster intervention has been developed that is taught over 10 class periods in the second year and 5 in the third year. This means the initial program should be implemented with sixth or seventh grade students, followed by booster sessions during the next 2 years.

The LifeSkills Training elementary school curriculum runs for 24 class sessions, each 30 to 45 minutes long, to be conducted over 3 years. The first year (i.e., Level 1) is composed of eight class sessions and covers all skill areas. The booster sessions provide additional skill development and opportunities to practice in key areas.

IMPLEMENTATION ESSENTIALS

LifeSkills Training is a completely self-contained prevention curriculum. To implement the program, in addition to a LifeSkills-trained provider (teacher, counselor, or health professional), all that is required is a curriculum set consisting of a Teacher's Manual, Student Guide, and relaxation tape.

Provider training is available for individuals interested in conducting the LifeSkills program. All training is conducted by qualified trainers who are certified by National Health Promotion Associates, Inc.

Multisystemic Therapy (MST)

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PROVEN RESULTS*

- Decreased adolescent substance use
- Decreased adolescent psychiatric symptoms
- Reduced long-term rearrest rates 25% to 70%
- Reduced long-term out-of-home placement 47% to 64%
- Improved family relations and functioning
- Increased mainstream school attendance
- Considerable cost savings over other social services (up to $131,000 per youth)

* In comparison with control groups in eight randomized research projects.

Multisystemic Therapy (MST) is a family-oriented, home-based program that targets chronically violent, substance-abusing juvenile offenders 12 to 17 years old. It uses methods that promote positive social behavior and decrease antisocial behavior, including substance use, to change how youth function in their natural settings (i.e., home, school, and neighborhood). The primary goals of MST are to:

- Reduce youth criminal activity
- Reduce antisocial behavior, including substance abuse
- Achieve these outcomes at a cost savings by decreasing incarceration and out-of-home placement rates

Based on the philosophy that the most effective and ethical route to help youth is through helping their families, MST views parents or guardians as valuable resources, even when they have serious and multiple needs of their own. A "multisystemic" approach, however, views these youth as involved in a network of interconnected systems that encompass individual, family, and extra-familial (e.g., peer, school, neighborhood) factors, and recognizes that it is often necessary to intervene in more than one of these systems. MST addresses these factors in an individualized, comprehensive, and integrated manner.

PROGRAM BACKGROUND

The current form of MST is the result of extensive scientific evaluation. To date, eight randomized clinical research trials have been published and, in 2001, more than a dozen additional randomized trials evaluating MST were underway. The strength of these results has lead to the program's dissemination throughout the United States and around the world. MST is currently used in over 25 States, Norway, England, Ireland, Sweden, New Zealand, and Canada.The Family Services Research Center, the MST-focused research group at the Medical University of South Carolina, has supported the dissemination of MST since the early 1990s. In 1996, a university-affiliated organization, MST Services, was formed to help communities establish MST programs.

TARGET POPULATION

MST targets chronic, violent, or substance-abusing male and female juvenile offenders at risk of out-of-home placement. The "typical" MST youth is 12 to 17 years old, has multiple arrests or an arrest for a violent offence, is deeply involved with delinquent peers, has problems at school or does not attend, abuses multiple drugs (e.g., marijuana, alcohol, and cocaine), and lives in a single-parent household that has multiple needs and problems. MST is equally effective with families who have different strengths and weaknesses and who come from a range of socioeconomic and ethnic backgrounds.

Target Areas

Protective Factors To Increase

Individual
- Youth coping strategies (e.g. social skills, personal hygiene skills, impulse control etc.)

Peer
- Association with positive peers
- Involvement in prosocial activities

Family
- Positive family relations and functioning
- Parental monitoring
- Rule setting and positive rewards in the home
- Family engagement with neighbors and access to community resources
- Planned between-family monitoring of youth group activities

School
- Mainstream school attendance and performance
- Youth involvement in school and after-school activities
- Relationship between parental figures and school

Community
- Family awareness of and access to existing community resources

Risk Factors To Decrease

Individual
- Antisocial and criminal behaviors
- Psychiatric symptoms in youth

Peer
- Association with negative peers

School
- School failure

Family
- Conflict in the home
- Psychiatric symptoms in caregivers

OUTCOMES

MST has proven effective in reducing substance use and antisocial behavior among diverse populations of serious and chronic juvenile offenders. Followup studies with youth and families 2 and 4 years after completing the program supported the long-term effectiveness of MST. In addition, despite its intensity, MST was a relatively inexpensive intervention. With a small client to therapist ratio (4:1) and a course of treatment lasting 3 to 5 months, the cost per client for treatment in the MST group was about one-fifth the average cost of an institutional placement. A recent study by the Washington State Institute for Public Policy estimated savings of $31,000 to $131,000 for each youth served.

BENEFITS

MST youth:
- Were significantly less likely to use substances
- Had fewer arrests for all types of offenses
- Spent less time in out-of-home placements
- Engaged in less aggression with peers
- Were less likely to be involved in criminal activity

HOW IT WORKS

MST typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period.

IMPLEMENTATION ESSENTIALS

MST requires:
- Dedicated full-time clinical staff of three to five people, including a supervisor, who work as a clinical "team"
- Staff availability 24 hours a day, 7 days a week
- Small caseloads of four to six families per therapist
- Buy-in from community members and social service agencies (e.g., child welfare, probation, etc.) to allow the MST therapist to take the lead in clinical decisionmaking and treatment planning for the youth and family (and not be kept from achieving positive outcomes because of existing policies and procedures)
- Commitment to MST supervision and training protocols
- Outcome-based discharge criteria (i.e., observable youth behavior change)
- Treatment cycles of 3 to 5 months on average
- Emphasis on knowledgeable, experienced staff (e.g., MAin counseling, M.S.W., etc.)

Nurse-Family Partnership (NFP)

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PROVEN RESULTS*

- Improved birth outcomes
- Reduced rates of subsequent pregnancy
- Reduced rates of childhood injury, abuse, and neglect
- Decreased smoking and alcohol use, especially among teenage mothers.

* Outcomes relative to controls.

The Nurse-Family Partnership (NFP) provides first-time, low-income mothers of any age with home visitation services from public health nurses. NFP nurses work intensively with these mothers to improve maternal, prenatal, and early childhood health and well being with the expectation that this intervention will help achieve long-term improvements in the lives of at-risk families. The intervention process is effective because it focuses on developing therapeutic relationships with the family and is designed to improve five broad domains of family functioning:

- Health (physical and mental)
- Home and neighborhood environment
- Family and friend support
- Parental roles
- Major life events (e.g., pregnancy planning, education, employment)

Starting with expectant mothers, the program addresses substance abuse and other behaviors that contribute to family poverty, subsequent pregnancies, poor maternal and infant outcomes, suboptimal childcare, and a lack of opportunities for the children.

PROGRAM BACKGROUND

NFP was originally started as a research study in Elmira, NY in the late 1970s. Because of the encouraging findings, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) made NFP part of their "Weed and Seed" initiative, funding the program in six demonstration cities. In 1999, NCCFC was established to disseminate the program nationwide. Currently, NFP programs operate in 22 States.

TARGET POPULATION

NFP serves first-time mothers who have little or no income. Ultimately, their baby and everyone who makes up their supportive environment (e.g., friends, boyfriend or child's father, her parents, etc.) gets involved in the program, but the primary client is the first-time mother. Some program sites choose to focus exclusively on teen mothers, but this is an option.

OUTCOMES

NFP produced consistent benefits for low-income mothers and their children through the child's fourth year in the areas of:

- Mother's prenatal health (especially in relation to their use of cigarettes)
- Injuries to children

Target Areas

Protective Factors To Increase

Individual
- Good parenting skills
- Knowledge of substance use effects on pregnancy
- Knowledge of proper prenatal care
- Knowledge of child development

Family
- Support for using needed services
- Involvement of father and/or other family members

Risk Factors To Decrease

Individual
- Unemployment or low levels of income
- Conduct disorders
- Criminal involvement or delinquency
- Positive attitude toward substance use
- Lack of parenting skills
- Early onset of sexual activity and multiple sexual partners
- Single and/or teenage mothers

Family
- Abuse or violence

- Rates of subsequent pregnancy
- Use of the social welfare system

A 15-year follow-up study of the Elmira sample found that the program:
- Reduced child abuse and neglect 79%
- Reduced maternal behavioral problems, due to substance use, 44%
- Reduced arrests among the mothers 69%
- Resulted in 54% fewer arrests and 69% fewer convictions among the 15-year-old adolescents
- Resulted in 58% fewer sexual partners among the 15-year olds
- Reduced cigarette smoking by the 15-year old adolescents 28%

BENEFITS

- Improved birth outcomes through the reduction of pre-term and low birth weight babies
- Improved parenting and the home environment
- Reduced quickly reoccurring and unintended pregnancies
- Increased participation in the work force
- Reduced the incidence of conduct disorders, involvement in crime, and delinquency
- Saved four dollars for every dollar invested, due to reduced welfare, fewer arrests and lower health care (especially emergency room) costs

HOW ITWORKS

NFP represents a refined version of the long-established service strategy of home visitation; it achieves results by providing visits from highly trained public health nurses. These visits usually take place in the client's home but can occur at other locations when necessary.

IMPLEMENTATION ESSENTIALS

The program meets its objectives by addressing several key components that research and experience have shown to be important:
- The program focuses on first-time mothers with little or no income.
- The home visitors are registered nurses.
- Nurses follow program guidelines that focus on the mother's personal health, quality of caregiving for the child, and parents'own development.
- Nurses begin making home visits while the mother is still pregnant and continue through the first 2 years of the child's life.
- Nurse home visitors employ a visit schedule that follows the developmental stages of pregnancy and early childhood.
- Nurses work with the mother's existing support system, including family members, fathers when appropriate, and friends, to help families access other health and human services they may need.
- Each nurse home visitor carries a caseload of no more than 25 families.
- The organization implementing the program provides a well-prepared half-time nursing supervisor for every four nurse visitors.
- The program is located in and run by an organization known in the community for providing quality services to low-income families.
- Program staff uses the Clinical Information System that has been designed for the model to keep track of family characteristics, needs, services provided, and progress toward accomplishing objectives.

Olweus Bullying Prevention Program

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PROVEN RESULTS*

- A 30% to 70% reduction in student reports of being bullied and bullying others; results are largely parallel with peer ratings and teacher ratings
- Significant reductions in student reports of general antisocial behavior (e.g., vandalism, fighting, theft, and truancy)
- Significant improvements in classroom order and discipline
- More positive attitude toward schoolwork and school.

* Outcomes relative to controls.

The Olweus Bullying Prevention Program is a multilevel, multicomponent school-based program designed to prevent or reduce bullying in elementary, middle, and junior high schools (students 6 to 15 years). The program attempts to restructure the existing school environment to reduce opportunities and rewards for bullying. School staff is largely responsible for introducing and implementing the program. Their efforts are directed towards improving peer relations and making the school a safe and positive place for students to learn and develop.

While intervention against bullying is particularly important to reduce the suffering of the victims, it is also highly desirable to counteract these tendencies for the sake of the aggressive student, as bullies are much more likely than other students to expand their antisocial behaviors. Research shows that reducing aggressive, antisocial behavior may also reduce substance use and abuse.

PROGRAM BACKGROUND

In 1983, after three adolescent boys in northern Norway committed suicide, most likely as a consequence of severe bullying by peers, the country's Ministry of Education commissioned Professor Dan Olweus to conduct a large-scale research and intervention project on bully/victim problems. The resulting Olweus Bullying Prevention Program, developed at the University of Bergen in Norway, has been refined, expanded, and evaluated with positive results in two new large-scale projects in Norway. As part of the Norwegian Government's plans for the prevention of delinquency and violence among children and youth, the Olweus Program is now being implemented on a large-scale basis all over Norway. The program has also been successfully implemented in other countries, including the United States, the United Kingdom, and Germany. During the 1990s, Professor Olweus worked closely with a number of colleagues in the United States, notably Dr. Sue Limber and Dr. Gary Melton at Clemson University in South Carolina, to implement and evaluate the program in the U.S.

TARGET POPULATION

Olweus Bullying Prevention Program targets students in elementary, middle, and junior high schools. All students participate in most aspects of the program, while students identified as bullying others or as targets of bullying receive additional individual interventions.

Target Areas

Risk Factors To Decrease

Individual
- Impulsive, hot-headed, dominant personality
- Lack of empathy
- Difficulty conforming to rules
- Low frustration for tolerance
- Positive attitudes toward violence
- Physical strength (boys)
- Gradually decreasing interest in school

Peer
- Friends/peers with positive attitudes toward violence

School
- Indifferent or accepting teacher attitudes toward bullying
- Indifferent or accepting student attitudes toward bullying

Family
- Lack of parental warmth and involvement
- Overly-permissive parenting
- Harsh discipline/physical punishment
- Lack of parental supervision

OUTCOMES
Some key results are reported under the heading Proven Results.

BENEFITS
- Reduces existing bullying/victim problems
- Prevents development of new cases of bullying
- Improves peer relations at the school

HOW IT WORKS
Olweus Bullying Prevention works with interventions at three levels:

- **Schoolwide Interventions**
  Administration of the Olweus Bully/Victim Questionnaire, formation of a Bullying Prevention Coordinating Committee, staff training, development of school rules against bullying and development of a coordinated system of supervision during break periods.
- **Classroom-level Interventions**
  Regular classroom meetings about bullying and peer relations and class parent meetings
- **Individual-level Interventions**
  Individual meetings with children who bully and with children who are targets of bullying and meetings with parents of children involved

IMPLEMENTATION ESSENTIALS
Implementation of the Olweus Bullying Prevention Program requires significant and ongoing commitment from school administrators, teachers, and other staff. A first step is to establish a Bullying Prevention Coordinating Committee comprised of administrators, teachers, students, parents, and the program's Onsite Coordinator.

Training
All school staff participate in a half- to 1-day training session. Additionally, school personnel on the Bullying Prevention Coordinating Committee participate in a 1.5-day training with a certified trainer and attend one to two hour monthly meetings.

Program Management and Timing
Depending on the school's size, a program will require a part- or full-time Onsite Coordinator. The optimal approach to program implementation involves selecting the Onsite Coordinator and administering the questionnaire survey in the Spring; training staff in August, before school opens; and holding a schoolwide kickoff at the beginning of the Fall semester.

Technical Assistance
Technical assistance is available for interested schools.

Program Resources
It is required that a copy of the Teacher Handbook and Bullying at School be purchased for each teacher. Other required materials are available through Olweus.

Positive Action (PA)

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PROVEN RESULTS

- Violence and substance use reduced 26% to 56%
- Academic achievement improved 12% to 65%
- General discipline improved by 23% to 90%
- Absenteeism improved 6% to 45%
- Truancy decreased by 14% to 20%
- Suspensions reduced 8% to 81%

Positive Action (PA) is an integrated, comprehensive, and coherent program that has been shown to improve the academic achievements and behaviors of children and adolescents (5 to 18 years old) in multiple domains. It is intensive, with lessons at each grade level (from kindergarten to 12th) that are reinforced all day, schoolwide, at home, and in the community. It includes school, family, and community components.

For students, Positive Action improves:

- Individual self-concept
- Academic achievement and learning skills
- Decisionmaking, problem solving, and social/interpersonal skills
- Physical and mental health
- Behavior, character, and responsibility

PA improves school climate, attendance, test scores, disciplinary referrals/suspensions, parent and community involvement, services for special-need and high-risk students, efficiency and effectiveness. Positive Action positively affects instruction and classroom/school management skills of school personnel through improved self-concept, professionalism, and interpersonal/social skills and, in turn, has a positive impact on their personal lives. Finally, Positive Action helps families by improving parent-child communication and overall family attitudes toward and involvement in school and the community.

PROGRAM BACKGROUND

PA was developed in Twin Falls, Idaho between 1974 and 1982, at which time the Positive Action Company was founded. The program has been used in more than 7,000 schools nationally and internationally. Development and refinement of the program is ongoing.

PA is based on the intuitive philosophy that "you feel good about yourself when you do positive things." The program aligns schools, parents, and communities in promoting specific positive actions for youth that affect them physically, intellectually, socially, and emotionally.

TARGET POPULATION

PA involves all members of a school community: students, faculty, support staff, administrators, student family members, and people who live in the community surrounding the school. It is effective in urban, suburban, and rural areas and with all ethnic and cultural groups as well as with special needs students.

Target Areas

Protective Factors To Increase

Individual

- Positive personal characteristics (e.g., cooperation, self-concept, self-discipline, motivation to succeed)
- Healthy ethical, social, and emotional development
- Social skills (e.g., communication, problem solving, conflict resolution, positive empathy)
- Positive bonding to social institutions and values, including school
- Commitment to prosocial values

Peer

- Association with peers who are involved in school
- Association with peers who engage in positive behaviors

Family

- Bonding and attachment with parents and siblings
- Positive parenting (e.g., avoiding use of criticism, modeling and reinforcing positive behavior and accomplishment)
- Emotionally supportive family (e.g., knowledge of child's friends and their parents, involvement in homework and school activities)
- Frequent positive communication

School

- Caring and supportive teachers, staff, and school climate
- Environment reinforces positive behavior
- Teacher warmth and positive role modeling

Community

- Student, parent, and school involvement with community

Risk Factors To Decrease

Individual

- Inadequate self-concept, confidence or social skills
- Problem or unhealthy behaviors
- Susceptibility to peer pressure

Peer

- Delinquent peers

School

- Disorganized, chaotic, lax, or inconsistent rules
- Lack of teacher warmth, positive role modeling and reinforcement

Family

- Family disorganization and conflict
- Lack of involvement

Community

- Community disorganization
- Easy availability of drugs

PA is primarily implemented in grades K through 12, in before- and after-school programs, within Even Start and Head Start programs, and during extracurricular, family, and community activities. It may be implemented in whatever environment best suits the intervention including social service agencies, businesses, criminal justice agencies, faith-based institutions, and mental health service agencies.

OUTCOMES

Data from a study that used a matched case-control design found that, compared to the control group, a large Nevada school district that used PA:

- Reported 85% fewer violent incidents per 1000 students
- Scored 14% higher in their fourth grade achievement scores

BENEFITS

- Develops healthy, self-motivated children who avoid harmful behaviors and substances
- Develops educators who are professional, caring, and competent
- Develops parents who are involved with their children's education and school, and who teach and reinforce program goals at home
- Offers students a quality after-school program
- Motivates community activists to link their community groups to local schools

HOW IT WORKS

Ideally, a PA school implements the program schoolwide, and reinforces positive actions throughout the day. The principal, PA Coordinator, and PA Committee guide the program. Classroom teachers teach the curriculum, using a grade-appropriate kit containing prepared materials and a manual with lesson plans. Counselor and special education materials are included.

Parents receive a Family Kit that contains lessons and materials that correlate with the school program, supports parenting classes. The Community Kit is used to organize a steering committee that guides community partners to develop and coordinate positive community initiatives and activities.

IMPLEMENTATION ESSENTIALS

First and foremost, the Positive Action program requires willing faculty, administrative staff, parents, community members, and, most importantly, a principal who will provide primary leadership. Key staff includes:

- Positive Action Committee—This group is comprised of a teacher from every grade level, the principal or designee, assistant principals, a counselor, a school nurse, a support staff representative, several parents, and one or two students. They oversee program implementation.
- Positive Action Coordinator—This person may be the principal or a designee, and is responsible for coordinating the Positive Action Committee and monitors day-to-day program activities.
- Parent Coordinator—Amember of the Positive Action Committee, this individual provides information to parents and sets up parenting classes.
- Community Coordinator—Coordinates the community steering committee and plans activities.

Preparing for the Drug Free Years® (PDFY)

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J. David Hawkins, Ph.D.

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PROVEN RESULTS

- Reduced substance use 2 years after the intervention was completed
- Among those not using substances at 1-year followup, more remained substancefree at 2-year followup (relative risk reduction of 26%)
- Among those using substances at 1-year followup, fewer had progressed to more serious substances at the 2-year followup
- Significantly lower rates of increase in initiation of drinking to drunkenness and marijuana use over a 4-year period
- Less drinking in the past month (relative reduction of 40.6%)
- Increased parent communication of substance-abuse rules and consequences
- Greater involvement in family activities and decisions and better ability to manage anger and conflict

Preparing for the Drug Free Years® (PDFY) is a multimedia program that gives parents of children in grades four through eight (8 to 13 years old) the knowledge and skills needed to guide their children through early adolescence. Over the last 20 years, research has shown that positive parental involvement is an important protective factor that increases school success and buffers children against later problems such as substance abuse, violence, and risky sexual behaviors. This program aims to:

- Strengthen and clarify family expectations for behavior
- Enhance the conditions that promote bonding in the family
- Teach skills to parents and children that allow children to successfully meet the expectations of their family to resist drug use

PROGRAM BACKGROUND

PDFY grew from research that showed that positive parental involvement is an important factor in helping children resist substance use and other anti-social behaviors. PDFY's curriculum was developed to teach parents the skills they need to reduce the risk factors and enhance the protective factors that can help prevent substance abuse in their families.

The PDFY curriculum was field-tested for 2 years in 10 Seattle public schools before being made into a video-assisted program for wider distribution in 1987. Since 1987, PDFY has been implemented in more than 30 States and in Canada. The program has trained more than 120,000 families.

TARGET POPULATION

PDFY, which targets families with children aged 8 to 13, works with parents and children from various ethnic and socioeconomic backgrounds. It has been tested with Hispanic, African-American, Samoan, Native American, and Caucasian families. It has been implemented in diverse urban and rural communities across the United States.

OUTCOMES

- Significant effects on targeted parenting behaviors were found at posttest and maintained 1 year later.
- At the 2-year followup, youth in the PDFY group who had not initiated substance use at the 1-year followup were significantly more likely to have remained non-users than their counterparts in the control group. Youth in the PDFYgroup who had initiated substance use at the 1-year followup were significantly less likely to have

Target Areas

Protective Factors To Increase

Individual
- Healthy beliefs and clear standards for behavior

Family
- Opportunities for children to be involved in and contribute to the family
- Skills for family communication and problem solving
- Recognition of new skills and family involvement
- Family bonding

Risk Factors To Decrease

Individual
- Early initiation of substance use
- Favorable attitudes toward substance use

Peer
- Friends who engage in problem behaviors

Family
- Poor family management
- Family conflict
- Parental involvement in problem behaviors and attitudes favorable to problem behaviors

progressed to more frequent or varied substance use than youth in the control group.

BENEFITS

PDFY increases parents'ability to:

- Provide teenagers with appropriate opportunities for involvement in the family
- Recognize competencies and skills
- Teach children how to keep their friends and popularity while using drug-refusal skills
- Set and communicate healthy beliefs and clear standards for children's behavior

HOW IT WORKS

PDFY comprises five 2-hour sessions usually held over 5 consecutive weeks. Curriculum can also be presented in ten 1-hour sessions. Session topics include:

- How to prevent substance abuse in your family
- Setting clear family expectations regarding drugs and alcohol
- Avoiding trouble
- Managing family conflict
- Strengthening family bonds

The sessions are interactive and skill-based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and other parents. Video-based nignettes demonstrate parenting skills through the protrayal of a variety of family activities. Families also receive a Family Guide containing family activities, discussion topics, skill-building exercises, and information on positive parenting. The program has been offered to parents in schools, worksites, faith communities, community centers, homes, hospitals and prisons.

IMPLEMENTATION ESSENTIALS

The workshop leaders who conduct PDFY should be skilled in providing parenting workshops, understand the principles of adult learning, and be knowledgeable about risk and protective factors as they relate to prevention. It is highly recommended that workshop leaders attend a 3-day workshop leader's training event.

The PDFY workshop site should be in an accessible, safe, and familiar part of the neighborhood. The site should have enough meeting space to comfortably accommodate parents and their children and should be equipped with video equipment, an easel or chalkboard, and an overhead projector (or computer-based LCD projector). All other materials for the workshop come with the purchase of the PDFY Workshop Kit or are provided when attending a PDFY workshop leader's training event.

Project ACHIEVE

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PROVEN RESULTS*

- Overall discipline referrals to the ffice decreased 16%
- Out of school suspensions decreased 29%
- Grade retentions decreased 47%
- Special education referrals decreased 61%
- School bus discipline referrals to the office decreased 26%

* Comparison of prior year data from one of many studied schools with the data averaged after 8 years of program implementation at the same school.

Project ACHIEVE is an innovative school reform and school effectiveness program developed for use in preschool, elementary, and middle schools (students 3 to 14 years old). It is designed to help schools, communities, and families develop, strengthen, and solidify their youths' resilience, protective factors, and self-management skills. Project ACHIEVE works to improve school and staff effectiveness, and places particular emphasis on increasing student performance in the areas of:

- Social skills and social-emotional development
- Conflict resolution and self-management
- Achievement and academic progress
- Positive school climate and safe school practices

Project ACHIEVE implements schoolwide positive behavioral and academic prevention programs that focus on the needs of all students. It also develops and implements strategic intervention programs for at-risk and underachieving students, and it coordinates comprehensive and multifaceted "wrap-around" programs for students with intensive needs.

PROGRAM BACKGROUND

Project ACHIEVE, developed by Dr. Howard Knoff at the University of South Florida, began as a district-wide training program for school psychologists, guidance counselors, social workers, and elementary-level instructional consultants. It is now a school-based improvement, professional development, and technical consultation program that targets and reinforces critical staff skills and intervention approaches for an entire school. Since 1990, Project ACHIEVE has been implemented in schools and school districts across the country. To date, almost 1,500 schools in more than 40 States have been trained in one or more of its components.

TARGET POPULATION

Project ACHIEVE has been replicated at more than 25 sites across the United States. Its target audience is predominantly elementary and middle school children, however, program components also have been used in high schools, alternative schools, psychiatric and juvenile justice facilities, Head Start and after-school programs, and a number of specialized Charter Schools.

Target Areas

Protective Factors To Increase

Individual
- Positive sense of self
- Belief in society's values
- Prosocial behavior and conflict resolution skills
- Communication and problem-solving skills
- Responsiveness, empathy, and caring
- Goal-directedness and self-discipline
- Cooperation and flexibility
- Strengthened commitment to school

Family
- Avoidance of severe criticism
- High but realistic parental expectations
- Clear and consistent expectations
- Emotionally supportive family environment
- Orderly and structured parent–child relationships
- Parent involvement in homework and school-related activities

School
- Caring and supportive environment
- Sense of community in classroom and school
- Reinforced high expectations from school personnel
- Clear standards and rules for appropriate behavior

Risk Factors To Decrease

Individual
- Lack of self-control, assertiveness, and other social and emotional skills
- Low self-esteem and self-confidence
- Emotional and psychological problems
- School failure
- Conduct problems and early antisocial behavior, (e.g., lying, stealing, aggression)
- Economic disadvantage

Peer
- Susceptibility to negative peer pressure
- Need to respond to peer teasing, taunting, and bullying

School
- Poor school performance and high absenteeism
- Ambiguous, lax, or inconsistent rules and sanctions for student behavior
- Harsh, arbitrary, or disproportionate student management practices
- Poor sense of community in school
- Lack of parental involvement in schooling!

Family
- Poor child supervision and discipline
- Unrealistic expectations for development

OUTCOMES

In addition to reduced behavioral problems, a comparison of prior-year data with the averages from 8 years of Project ACHIEVE implementation at one of the studied schools, showed academic gains on the California Test of Basic Skills (CTBS) test.

BENEFITS

This program helps to:
- Maximize student academic achievement
- Create safe and positive school climates
- Increase and sustain effective classroom instruction
- Increase and sustain strong parent-school involvement
- Teach students social skills and self-management behavior

HOW IT WORKS

Project ACHIEVE is implemented by following a series of carefully sequenced steps that generally occur over a 3-year period. The program uses professional development, inservice, and technical assistance to train school personnel at each facility. Successful replication of the Project ACHIEVE model involves seven interdependent components.

IMPLEMENTATION ESSENTIALS

The "Stop & Think Social Skills Program" is Project ACHIEVE's curriculum for teaching students appropriate behavior and self-management skills. It includes the Social Skills book and support materials that allow teachers to organize and implement a social skills program. A RQC workbook, which describes the problem-solving and strategic intervention approach and provides step-by-step training and examples of how to use it with individually referred students, is also available. Using these materials, Project ACHIEVE is best installed in this sequence:

- Year 1 activities involve Social Skills training; RQC problem solving training; and providing teachers with release time for planning, meetings, and technical assistance.
- Year 2 activities include Social Skills/RQC training and booster sessions, Behavioral Observation and Instructional Environment Assessment training; Curriculum-Based Assessment and Measurement (CBA/CBM) training; and release time for planning, meetings, and technical assistance.
- Year 3 implementation requires booster sessions in all prior components; parent involvement planning, training and facilitation; grade-level intervention planning and implementation; and release time for planning, meetings, and technical assistance.

Beyond Year 3, Project ACHIEVE schools provide approximately 1 day per month of release time for teachers to plan and implement the activities identified in their action plans.

Other Project ACHIEVE materials are provided during professional development workshops as different components of the Project are implemented. Training and technical assistance is available and supported through public and private funding.

Project ALERT

Program Developer
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For information on techer training, curriculum materials, technical assistance, and cost, contact:

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PROVEN RESULTS*

Students receiving Project ALERT:

- Reduced initiation of marijuana use by 30%
- Decreased current marijuana use by 60%
- Reduced past month cigarette use by 20% to 25%
- Decreased regular and heavy smoking by 33% to 55%
- Substantially reduced students' prodrug attitudes and beliefs

* Compared with control groups.

Project ALERT is a drug prevention curriculum for middle-school students (11 to 14 years old), which dramatically reduces both the onset of substance abuse and their regular use. The 2-year, 14-lesson program focuses on the substances that adolescents are most likely to use: alcohol, tobacco, marijuana, and inhalants. Project Alert use participatory activities and videos to help:

- Motivate adolescents against drug use
- Teach adolescents the skills and strategies needed to resist prodrug pressures
- Establish nondrug-using norms

Guided classroom discussions and small group activities stimulate peer interaction and challenge student beliefs and perceptions, while intensive role-playing activities help students learn and master resistance skills. Homework assignments that also involve parents extend the learning process by facilitating parent-child discussions of drugs and how to resist using them. These lessons are reinforced through videos that model appropriate behavior.

PROGRAM BACKGROUND

In the early 1980s, the RAND Corporation, an internationally recognized nonprofit institution established to improve policy and decision-making through research and analysis, assessed the effectiveness of three major strategies for curtailing adolescent drug use: prevention, law enforcement, and treatment. Based on that study's conclusions, the Conrad N. Hilton Foundation funded RAND to develop and test Project ALERT between 1983 and 1993. National dissemination of the program, underwritten by the Hilton Foundation, began in 1991. Project ALERT has a presence in all 50 States. More than 18,000 teachers in approximately 3,500 school districts use Project ALERT in their classrooms. RAND is now developing and testing an enhanced version of Project ALERT that is designed for high schools.

TARGET POPULATION

Project ALERT is highly effective with middle-school adolescents, 11 to 14 years, from widely diverse backgrounds and communities. The program has proved successful with high- and low-risk Caucasian, African-American, Hispanic, Asian-American and Native American youth from urban, rural, and suburban communities and a variety of socioeconomic backgrounds. The original program was tested in schools in different geographic areas with different population densities, and among students with a range of racial/ethnic and economic backgrounds.

OUTCOMES

Project ALERT was effective in schools with both large and small minority populations from a variety of socioeconomic backgrounds, with youth experimenting with drugs and at risk for becoming regular users, as well as those who had

Target Areas

Protective Factors To Increase

Individual
- Reasons not to use drugs
- Perceptions that few peers use, most disapprove
- Belief that one can resist prodrug pressures
- Intentions not to use
- Belief that friends respect nonusers
- Ability to identify and counter advertising appeals
- Multiple strategies for resisting drugs
- Ability to identify and resist internal pressures to use

Peer
- Motivation and skills to help friends avoid drug use
- Responsible behavior modeled by peers

Family
- Communication with parents and other adults

School
- Establishment of norms against drug use
- Cooperative learning
- Respect for others

Risk Factors To Decrease

Individual
- Current use of alcohol, tobacco, or other drugs
- Intention to use in the future
- Belief that drug use is not harmful or has positive effects
- Belief that drug use is normal
- Low self esteem
- Inadequate resistance skills

Peer
- Peer drug use
- Peer approval of drugs

School
- High levels of drug use
- Low norms against use

Family
- Lack of clear norms against use
- Poor communication

not tried drugs before the program began. It substantially decreased prodrug attitudes and beliefs, including intentions to use drugs, beliefs that drug use is not harmful, and perceptions that many peers use drugs. It also increased beliefs that one can successfully resist both internal and external pressures to use drugs. The program markedly reduced the use of marijuana and cigarettes and the initiation of marijuana use.

BENEFITS

Project ALERT helps adolescents:
- Understand the consequences of using drugs
- Develop reasons not to use
- Understand the benefits of being drug-free
- Recognize that most people do not use drugs
- Identify and counter pro-drug pressures
- Resist advertising appeals
- Support others in their decisions not to use
- Learn how to quit
- Communicate with parents
- Recognize alternatives to substance use

HOW IT WORKS

Trained teachers typically deliver Project ALERT in a classroom setting, but some districts have adapted it for use in after-school settings where trained personnel are available.

Implementing Project ALERT involves staff in the following activities:
- Participating in a 1-day training workshop
- Teaching 11 core lessons during the first year and three booster lessons the following year
- Promoting parent involvement through home learning opportunities

To deliver lessons effectively, teachers need to establish an open, supportive classroom environment, facilitate student participation, reinforce good performance, help students acquire the confidence that they really can resist pro-drug pressures, and respond appropriately to student questions about drugs.

IMPLEMENTATION ESSENTIALS

Project ALERT lessons should be taught 1 week apart over the course of 11 weeks for Year 1 and 3 weeks for Year 2. Teachers need to participate in a 1-day training workshop where they learn the rationale and theory underlying Project ALERT, the skills needed to deliver the lessons, and implementation guidelines for achieving program fidelity. The location and dates of upcoming training workshops are listed on the program's Web site.

Teachers leave the training workshop with the following resources:
- A manual with 11 lessons for Year 1 and three booster lessons for Year 2
- Eight interactive student videos
- Twelve full-color classroom posters
- Demonstration videos of key activities and teaching strategies
- An overview video for colleagues and community members

Project ALERT periodically updates and distributes curriculum videos, posters, and other information to trained teachers free of charge.

Project Northland: An Alcohol Prevention Curriculum

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PROVEN RESULTS*

- Use of both alcohol and cigarettes was 27% lower in the intervention group
- Students who never drank at the beginning of the sixth grade smoked 37% fewer cigarettes and used 50% less marijuana at the end of eighth grade
- The intervention group felt less peer pressure to use alcohol
- Better parent-child communication about the consequences of alcohol use

* Relative to the control groups.

Project Northland is a multilevel, multiyear program proven to delay the age at which young people begin drinking, reduce alcohol use among those who have already tried drinking, and limit the number of alcohol-related problems of young drinkers. Designed for sixth, seventh, and eighth grade students (10 to 14 years old), Project Northland addresses both individual behavioral change and environmental change. Project Northland also strives to change how parents communicate with their children, how peers influence each other, and how communities respond to young adolescent alcohol use. Components include:

- Parent involvement and education programs
- Behavioral curricula
- Peer participation
- Community activities

Each intervention year has an overall theme and is tailored to the developmental level of the young adolescent. Alcohol is the focus of the Project Northland program because it is American teenagers' drug of choice and inflicts the greatest harm among youth.

PROGRAM BACKGROUND

Project Northland was developed at the University of Minnesota School of Public Health, Division of Epidemiology, and evaluated with a grant from the National Institute on Alcoholism and Alcohol Abuse (NIAAA). The evaluation was the largest and most rigorous alcohol use prevention trial ever funded by NIAAA, and Project Northland was shown to be effective in delaying and reducing alcohol use among young adolescents. After the initial evaluation, the programs underwent extensive pilot testing in a comparable Minnesota community, and revisions were made prior to implementation.

TARGET POPULATION

Project Northland is designed to provide state-of-the-art alcohol use prevention materials for students in grades six through eight. The original evaluation involved approximately 2,400 students from 24 school districts in northeastern Minnesota. This largely rural area is among U.S. communities rated highest for alcohol-related problems. A replication of the Project Northland study is currently underway in a major city.

Target Areas

PROTECTIVE FACTORS TO INCREASE

Individual
- Problem-solving skills
- Promotion of social competence, cooperation
- Cooperation
- Attachment to parents and other caring adults
- Belief in society's values

Peer
- Responsible behavior modeled by peer group/leader
- Stronger association with peers who are involved in school, recreation, service, religion, or other organized activities

Family
- Frequent and consistent communication with parents
- Presence of a significant adult
- Strong parental guidance
- Parent involvement in homework and school-related activities

School
- Sense of community in the classroom
- Clear standards and rules for appropriate behavior
- Youth participation, involvement, and responsibility in school tasks
- School bonding

Community
- Caring/support from community
- Opportunities for youth to participate in community activities

RISK FACTORS TO DECREASE

Individual
- Inadequate life skills
- Lack of peer-refusal skills
- Favorable attitudes toward alcohol use
- Lack of school bonding

Peer
- Association with delinquent peers and peers who reject mainstream activities
- Susceptibility to negative peer pressure

School
- Inconsistent rules and consequences related to alcohol use
- Lack of school bonding
- Favorable staff and student attitudes towards alcohol use

Family
- Family attitudes that favor alcohol use
- Poor child supervision and discipline
- Inconsistent rules and consequences related to alcohol use

Community
- Community disorganization
- Lack of community bonding
- Community attitudes favor alcohol use
- Inadequate youth services and opportunity for youth involvement in the community

OUTCOMES

Project Northland sustained widespread participation in the program, including 3 years of curricula implementation in all intervention schools, parent participation in alcohol education activities, and participation by nearly half of the students in peer-planned alcohol-free activities outside of school. Relative to controls, Northland participants:

- Drank significantly less at the end of eighth grade.
- Were significantly less likely to be users of both alcohol and cigarettes at the end of the eighth grade

Project Northland was effective in changing peer influence to use alcohol, normative expectations about how many young people drink, and parent-child communication about the consequences of alcohol use and the reasons for not using alcohol.

BENEFITS

- Teaches youth decisionmaking skills
- Assists in strengthening parenting skills
- Teaches youth interpersonal skills
- Provides information on substances of abuse

HOW IT WORKS

Project Northland consists of four components:

- Slick Tracy Home Team has sixth grade students and their parents complete fun and educational activities at home.
- Amazing Alternatives! provides curriculum for eight 45-minute sessions of teacher- and peer-led classroom sessions.
- PowerLines features eight 45-minute sessions that are part of a 4-week program for eighth grade students.
- Supercharged includes strategies that worked in Project Northland communities and provides schools with materials and a framework that can help them get parents and communities involved.

IMPLEMENTATION ESSENTIALS

Successful replication of the Project Northland model requires:

- Student involvement from sixth through eighth grades
- Teacher and peer training (recommended to maintain implementation fidelity)
- Incorporation of peer-selected peer leaders at all three grade levels
- A community member task force

Training and Technical Assistance

Project Northland, through Hazelden Information and Educational Services, can provide training of teachers and community coordinators based on local needs. Training can be conducted for one grade level each year or for all three grade levels at once. Hazelden also offers evaluation services.

Project SUCCESS

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PROVEN RESULTS*

- 23% reported ending substance ue
- 37% decrease in overall substance use
- Decreased problem behavior
- Decreased associtions with peers who use substances
- 45% reported ending marijuana use
- 23% reported ending tobacco use
- 33% reported ending alcohol use

* Relative to adolescents in comparison group who did not participate in Project Success. For those who did not quit drug use, there was a significant reduction in mean ATOD use.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) prevents and reduces substance use among high-risk, multiproblem high school adolescents. Developed and tested with alternative school youth 14 to 18 years old, the program places highly trained professionals in schools to provide a full range of substance use prevention and early intervention services.

In addition, Project SUCCESS links the school to the community's continuum of care when necessary, referring both students and families to human services organizations, including substance abuse treatment agencies.

PROGRAM BACKGROUND

Project SUCCESS began in September 1995 in three alternative secondary schools in Westchester County, NY, funded with a 3-year Center for Substance Abuse Prevention (CSAP) High Risk Youth Grant. The program is based on the effective Residential Student Assistance Program (RSAP) model, which had been used in residential facilities for troubled adolescents beginning in 1987 and which, in turn, was adapted from the Westchester Student Assistance Program. This latter program used interventions based on those developed for employee assistance programs. Project SUCCESS was designed to determine if the RSAP model could be adapted with adolescents at very high risk for substance abuse who were attending public alternative schools and living at home.

TARGET POPULATION

Project SUCCESS was tested with 14- to 18-year-old adolescents who attended an alternative school that separated them from the general school population. Participants typically came from low- to middle-income families, and 30 percent had parents who abused substances. The program is effective with African-American, Asian-American, Caucasian, and Hispanic youth of both genders. These adolescents have been placed in an alternative school setting for a variety of reasons including:

- Poor academic performance
- Emotional problems
- School discipline problems
- Truancy
- Negative attitude toward school
- Criminal activity

Target Areas

Protective Factors To Increase

Individual
- Self-efficacy and sense of mastery
- Social competence

Family
- Family protection

School
- Participation in school activities

Risk Factors To Decrease

Individual
- Favorable attitudes towards substances of abuse
- Depression
- Violence

School
- Poor school performance
- School dropout, failure, or high absenteeism

Family
- Substance abusing parents

OUTCOMES

Project SUCCESS was found to be effective with both genders, students from various ethnic groups, and across grade levels from the 9th to 12th grades. Project SUCCESS benefits not only students who participated directly in the program but also those students (the control group) who participate indirectly by associating with Project SUCCESS students.

BENEFITS

Project SUCCESS helps adolescents with emotional, learning, and behavioral problems expressed in behaviors such as fighting, cutting class, and talking back to teachers. The program teaches resistance and social competency skills for:

- Communication
- Decisionmaking
- Stress and anger management
- Problem solving
- Resisting peer pressure

HOW IT WORKS

A partnership is established between a prevention agency and alternative school. An individual with a graduate degree in social work, counseling, or psychology, who is experienced in providing substance abuse prevention counseling to adolescents, is recruited to work in the alternative school as a Project Success Counselor (PSC). This individual will provide the school with a full range of substance abuse prevention and early intervention services to help decrease risk factors and enhance protective factors related to substance abuse.

IMPLEMENTATION ESSENTIALS

Project Success requires formation of a partnership between a substance abuse prevention organization that will administer the program and an alternative school where it will operate. Specific staff participants include:

- School Principal who establishes the initial implementation agreement, selects the counselor, oversees the program, and supervises the counselor onsite.
- Executive Director/Project Director who initiates and manages the program, develops procedures, and hires staff.
- Project SUCCESS Counselor (PSC) who implements the program at the school, consults with the principal and teachers, engages in informal outreach activities with students and their parents, and provides all prevention and early intervention services to students.
- Project Supervisor who supervises the PSC and helps coordinate activities with school staff.

Program staff and administrators need to address the following steps:

1. Define program goals and objectives
2. Define target population
3. Provide training and consultation for school staff
4. Establish a school staff substance abuse task force
5. Obtain technical assistance and training

Project Toward No Drug Abuse (TND)

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PROVEN RESULTS*

- Cigarette use reduced 27%
- Marijuana use reduced 22%
- Alcohol use reduced 9%
- Other drug use reduced 26%
- Weapon carrying among males reduced 25%

* Relative to randomly asigned comparison,participants' showed decreased substance use in the last 30 days and in any weapon carrying during the last year.

Project Toward No Drug Abuse (TND) is a highly interactive program designed to help high school youth (14 to 19 years old) resist substance use. A school-based program, TND consists of twelve 40- to 50-minute lessons that include motivational activities, social skills training, and decisionmaking components that are delivered through group discussions, games, role-playing exercise, videos, and student worksheets. Project TND teaches participants increased coping and self-control skills that allow them to:

- Grasp the cognitive misperceptions that may lead to substance use and express a desire not to abuse substances
- Understand the sequence of substance abuse and the consequences of using substances
- Correct myths concerning substance use
- Demonstrate effective communication, coping, and self-control skills
- State a commitment to discuss substance abuse with others

PROGRAM BACKGROUND

Project TND was developed specifically to fill a gap in substance abuse prevention programming for senior high school youth. It is the result of an ongoing research project that has been funded by the National Institute on Drug Abuse since 1992. The theory underlying Project TND is that young people at risk for substance abuse will not use substances if they: 1) are aware of misleading information that facilitates substance use (e.g., myths about substance use, stereotyping), 2) have skills that help them lower their risk for use (e.g., coping skills, self-control), 3) appreciate the consequences that substance use may have on their own and others' lives (e.g., chemical dependency), 4) are aware of cessation strategies, and 5) have decisionmaking skills to make a commitment not to use substances.

TARGET POPULATION

Project TND was tested with Caucasian, African-American, Hispanic, and Asian-American adolescents, 14 to 19 years old, attending both regular and alternative schools.

OUTCOMES

Project TND-II participants in alternative high school (schools for high-risk students) experienced:

- A reduction in cigarette use of 27%
- A reduction in marijuana use of 22%

Target Areas

Protective Factors To Increase

Individual
- Accurate knowledge of the course of substance abuse, its consequences, and its prevalence
- Effective communication, listening skills, and behavioral and cognitive coping skills
- Empathetic understanding of the effects of substance abuse on others
- Knowledge of tobacco cessation strategies
- Understanding the importance of health in achieving life goals
- Self-control, assertiveness, and conflict resolution skills
- Self-awareness to moderate specific behaviors
- Decisionmaking skills
- Commitment to not use substances

Family
- Understanding of effects of substance abuse on the family and how to get help

School
- School commitment to not allowing substance use

Community
- Resistance to negative stereotyping

Risk Factors To Decrease

Individual
- Low self-esteem
- Self-defeating perceptions regarding substance use consequences
- Belief in substance use myths

- A reduction in higher levels of alcohol use of 9%
- A reduction in "hard" drug use of 26%
- Among males, a 25% reduction in weapons carrying

Project TND-I participants in regular high school experienced:

- A reduction in "hard" drug use of 25%
- A reduction in higher levels of alcohol use of 12%
- Among males, a 19% reduction in weapons carrying

BENEFITS

This program enables students to understand and express the cognitive misperceptions that may lead to substance use. Participants also state a commitment to discuss substance abuse with peers and not to abuse substances.

HOW IT WORKS

Project TND's 12 lessons are designed for presentation during a 4-week period, although they may be spread over 6 weeks if all lessons are taught. Project TND involves teacher-led student participation in interactive program components.

IMPLEMENTATION ESSENTIALS

Virtually any school or school district can implement Project TND. A single, trained classroom teacher delivers Project TND in a classroom setting to class sizes varying from 8 to 40 students. One to two days of teacher training prior to curriculum implementation is highly recommended.

Project TND offers an implementation manual providing step-by-step instructions for completing each of the 12 lessons. Program materials also include:

- A video on the need to eliminate substance abuse in order to achieve life goals
- A student workbook
- An optional kit containing other instructional materials (evaluation materials, the book, *The Social Psychology of Drug Abuse*, and Project TND outcome articles)

Project Toward No Tobacco Use (TNT)

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PROVEN RESULTS*

- Reduced initiation of cigarette use by approximately 26% when 1- and 2-year outcomes were averaged together
- Reduced initiation of smokeless tobacco use by approximately 30%
- Reduced weekly or more frequent cigarette smoking by approximately 60%
- Eliminated weekly or more frequent smokeless tobacco use

* Relative to the control group in a large randomized field experiment.

Project Toward No Tobacco Use (TNT) is a comprehensive, classroom-based curriculum designed to prevent or reduce tobacco use in youth. Designed for youth in grades five through ten (10 to 15 years old), upon completion of this program, students will be able to describe the course of tobacco addiction, the consequences of using tobacco, and the prevalence of tobacco use among peers. Delivered in 10 core and 2 booster lessons, TNT is proven effective at helping youth to:

- Resist tobacco use and advocate no tobacco use
- Demonstrate effective communication, refusal, and cognitive coping skills
- Identify how the media and advertisers influence youth to use tobacco products
- Identify methods for building their own self-esteem
- Describe strategies for advocating no tobacco use

Project TNT is designed to counteract several different causes of tobacco use simultaneously because the behavior is determined by multiple causes. This comprehensive approach works well for a wide variety of youth who may have different risk factors influencing their tobacco use.

PROGRAM BACKGROUND

Project TNT was initially funded, from 1987 to 1993, with a grant from the National Cancer Institute. The theory underlying Project TNT is that young people will be best able to resist using tobacco products if they (1) are aware of misleading social information that facilitates tobacco use (e.g., advertising, inflating prevalence estimates), (2) have skills that counteract the social pressures to gain peer approval by using tobacco, and (3) appreciate the physical consequences that tobacco use may have on their own lives (e.g., the beginnings of addiction).

TARGET POPULATION

Project TNT was completed originally with seventh grade students. It has been successfully implemented with Caucasian, Hispanic, African-American, and Asian-American adolescents, 1- to 15 years old.

OUTCOMES

The original experimental trial found that students in Project TNT reduced initiation of cigarettes by approximately 26 percent over the control group, when 1-year and 2-year followup outcomes were averaged together. Further, initiation of smokeless tobacco use was reduced by approximately 60 percent. Weekly or more frequent cigarette smoking by

Target Areas

Protective Factors To Increase

Individual
- Accurate knowledge concerning tobacco addiction and related diseases, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Effective communication, refusal, and cognitive coping skills
- Awareness of how the media and advertisers influence teens to use tobacco products
- Self-esteem
- Active use of strategies for advocating-no-tobacco use
- Knowledge how to quit tobacco use

Peer
- Responsible classroom behavior
- Enforcement of no-tobacco use at the school

Family
- Understanding of tobacco addiction among adults

Community
- Letter writing to discourage mass media promotion of tobacco use or products

Risk Factors To Decrease

Individual
- Incorrect information concerning tobacco use myths, tobacco use prevalence, and tobacco use social images
- Poor social skills
- Susceptibility to negative peer social influence

Peer
- Peer modeling of tobacco use and other risky behavior
- Peer influence to use tobacco

Family
- Family modeling of tobacco use
- Accessibility to tobacco products

Community
- Mass media promotion of tobacco use or products

School
- Evidence of tobacco use among school personnel or visitors to the school

students in the Project TNT group was reduced by approximately 30 percent. For students in the Project TNT group, weekly or more frequest smokeless tobacco use was eliminated.

BENEFITS

At the completion of this program, students will be able to:
- Describe the course of tobacco addiction and related diseases
- Demonstrate effective communication, refusal, and cognitive coping skills
- Identify how the media and advertisers influence teens to use tobacco products
- Identify methods for building their own self-esteem

HOW IT WORKS

Implementing Project TNT involves the following activities:
- A comprehensive, 10-day, classroom-based social influences program that examines media, celebrity, and peer portrayal of tobacco use
- Training in active listening, effective communication, and general assertiveness development along with methods for building self-esteem
- Education on the course of tobacco-related addiction and diseases; correction of inflated tobacco use prevalence estimates
- Learning tobacco-specific cognitive coping skills and assertive refusal techniques
- Practicing ways to counteract media portrayals of tobacco use, including social activism letter writing to make a public commitment to not using tobacco products
- Use of homework assignments, a classroom competition (i.e., the "TNT Game"), and a two-lesson booster program
- Longitudinal assessment material

IMPLEMENTATION ESSENTIALS

Successful replication of Project TNT involves delivering 10 core lessons and 2 booster lessons, each 40 to 50 minutes in length. The 10 core lessons are designed to occur during a 2-week period, although they may be spread over 4 weeks as long as all lessons are taught. The two-lesson booster is delivered 1 year after the core lessons in a 2-day sequence. However, the booster sessions may be taught one per week.
Project TNT offers an implementation manual that provides step-by-step instructions for completing each of the lessons, along with introductory and background materials.

Teacher Training

Project TNT can provide a 2-day teacher training prior to implementation. This training is highly recommended.

Reconnecting Youth (RY)

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PROVEN RESULTS*

- 18% improvement in grades in all classes
- 7.5% increase in credits earned per semester
- 54% decrease in hard drug use
- 48% decrease in anger and aggression problems
- 32% decline in perceived stress
- 23% increase in self-efficacy

* Compared to students not participating in Reconnecting Youth

Reconnecting Youth (RY) is a school-based prevention program for youth in grades nine through twelve (14 to 18 years old) who are at risk for school dropout. These youth may also exhibit multiple behavior problems, such as substance abuse, aggression, depression, or suicide risk behaviors. Reconnecting Youth uses a partnership model involving peers, school personnel, and parents to deliver interventions that address the three central program goals:

- Decreased drug involvement
- Increased school performance
- Decreased emotional distress

Students work toward these goals by participating in a semester-long high school class that involves skills training in the context of a positive peer culture. RY students learn, practice, and apply self-esteem enhancement strategies, decisionmaking skills, personal control strategies, and interpersonal communication techniques.

PROGRAM BACKGROUND

The development and framework for RY were largely informed by early descriptive work of Dr. Leona Eggert and her colleagues. Early work identified the vulnerabilities among youth at risk for high school dropout, "skippers," and the co-occurring problem behaviors of school deviance, drug involvement, and depression/suicidal behaviors. Reconnecting Youth was specifically designed to meet the participants'needs for inclusion and excitement while teaching them how to be "winners," stay in control, make wise decisions, and evaluate potential consequences of their choices. The program has been funded for testing by the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH) and the U.S. Department of Education (DOE) in suburban and urban areas of the Pacific Northwest. A two-semester version of the program, with a parent component, is currently being evaluated with funding from NIDA. RY has been adopted by Texas and Maine as an integral part of statewide prevention programming.

TARGET POPULATION

RY is highly effective with high school youth who are at risk for school dropout defined as having fewer than the average number of credits earned for their grade level, having high absenteeism, showing a significant drop in grades, or having a history of dropping out of school. The program was developed and tested in the greater Seattle area, and has been successfully implemented according to design in California, Colorado, Maine, Texas, and Washington. Students from a variety of racial and ethnic backgrounds, living in suburban and urban settings, have benefited from the program.

Target Areas

PROTECTIVE FACTORS TO INCREASE

Individual
- Communicate using self-esteem enhancing talk
- Decisionmaking and the ability to apply it to drug use, school, and mood management
- Personal control, stress, and mood management skills
- Interpersonal communication and negotiation skills

Peer
- Daily reinforcement of the positive peer group culture norms
- Replacing deviant peer/group belonging with prosocial group belonging

Family
- Practicing interpersonal communication skills at home
- Enlisting parent support for program goals

School
- Setting norms for and monitoring attendance, achievement, mood, and drug-use control
- School network support
- Facilitating prosocial activities

RISK FACTORS TO DECREASE

Individual
- Impulsiveness
- Poor decision-making and coping skills
- Uncontrolled emotions
- Learned helplessness
- Low self-worth; deviant self-image
- Poor social/interpersonal skills

Peer
- Deviant friends in peer group network
- Peers who skip school and use drugs
- Peers lacking personal goals related to school achievement and attendance
- Susceptibility to negative peer influences

School
- Negative view of school experience
- Norms of skipping school
- Substance use at school
- Poor teacher-student relationships
- Low access to help
- Nonparticipation in school activities

Family
- Family distress and serious conflicts
- Poor family-school connections
- Unclear/unfair rules

OUTCOMES

Relative to controls, high-risk youth participating in RY evidenced:

- Increased School Performance
- Decreased Drug Involvement
- Decreased Emotional Distress

BENEFITS

- Improved grades and school attendance
- Reduced drug involvement
- Decreased emotional distress
- Increased self-esteem, personal control, prosocial peer bonding, and social support

HOW IT WORKS

Four key RY components are integrated into the school environment. They are:

- RY Class, a core element, is offered for 50 minutes daily during regular school hours for one semester in a class with a student-teacher ratio of 10 or 12 to 1. After a 10-day orientation to the program, approximately 1 month is spent on each of these topics: self-esteem, decisionmaking, personal control, interpersonal communication
- School bonding activities
- Parental involvement, required for student participation, is essential for at-home support of the skills students learn in RY Class.
- School Crisis Response planning provides teachers and school personnel with guidelines for recognizing warning signs of suicidal behaviors and suicide prevention approaches.

IMPLEMENTATION ESSENTIALS

From planning through implementation of the RY curriculum, partnerships with school officials are vital. Typical partners include the RY Teacher, RY Coordinator, parents, designated district representative, the principal, vice principal, student support services, staff, and administrative support staff—especially attendance and registrar. Regular meetings to ensure readiness, commitment, and financial resources will help set a strong foundation for successful replication.

Room, Equipment, and Supplies

A classroom large enough to accommodate the RY teacher and 10 to 12 students is necessary. Teachers will need a copy of the Reconnecting Youth: A Peer Group Approach to Building Life Skills curriculum and will need to prepare student notebooks from handouts contained therein.

Training and Technical Assistance

For best results and to ensure implementation fidelity, all RY Teachers and Coordinators should receive implementation training. Onsite implementation training for potential RY Teachers and Coordinators is available from RY personnel. Initial implementation training lasts 5 days. Recommended followup implementation consultation of 1 day every 6 months during the first year of implementation, plus phone consultation. At least one yearly followup consultation, to manage implementation challenges and to assess implementation fidelity in subsequent years, also is recommended.

Residential Student Assistance Program (RSAP)

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PROVEN RESULTS*

- 68% decrease in overall substance use
- 72% reported ending alcohol use
- 59% reported ending marijuana use
- 27% reported ending tobacco use
- 82% of alcohol nonusers remained nonusers
- 83% of marijuana nonusers remained nonusers
- 79% of tobacco nonusers remained nonusers

* Relative to adolescents in comparison groups who did not participate in the RSAP.

The Residential Student Assistance Program (RSAP) is a substance abuse prevention program developed for high-risk adolescents (14 to 17 years old) living in residential facilities. The program is based on the Westchester Student Assistance Model and works by placing highly trained professionals in residential facilities to provide residents with a full range of substance abuse prevention and early intervention services. The program uses proven prevention strategies that include:

- Information dissemination
- Normative and preventive education
- Problem identification and referral
- Community-based interventions
- Environmental approaches

RSAP counselors work with adolescents individually and in small groups. Intervention services are fully integrated into the adolescent's overall experience at the residential facility and have an impact on both their school and residential environments.

PROGRAM BACKGROUND

RSAP began in 1987 as a 5-year demonstration program in Westchester County, New York, funded through a Center for Substance Abuse Prevention High-Risk Youth Grant. The program model was based on employee assistance programs successfully used by industry to identify and aid employees whose work performance and lives had been adversely affected by substance abuse. Other experiences contributing to this program's design came from the County's successful implementation of the Westchester Student Assistance Programs within its high schools. This program intended to adapt that model for institutionalized adolescents at a very high risk for substance abuse. The residential facilities participating in the demonstration project included a locked county correctional facility, a residential treatment center for emotionally disturbed adolescents, a non-secure residential facility and three foster care facilities.

TARGET POPULATION

RSAP was tested with 14- to 17-year-old adolescents, primarily African-American and Hispanic, living in various residential facilities. Whether voluntarily or involuntarily placed in such facilities, these youth typically present with multiple risk factors and problems, including early substance use; parents who abuse substances; participation in violent or delinquent acts; histories of physical, sexual, or psychological abuse; chronic failure in school; and mental health problems, including attempted suicide.

OUTCOMES

Adolescents participating in RSAP showed dramatic reductions in their use of alcohol, marijuana, and tobacco from

Target Areas

PROTECTIVE FACTORS TO INCREASE

Individual
- Self-efficacy and sense of mastery
- Social competence

Family
- Distancing from chemically dependent parents

RISK FACTORS TO DECREASE

Individual
- Juvenile justice and criminal involvement
- Severe emotional problems or mental disabilities
- Suicidal ideation

Family
- Parental substance abuse
- Abuse and neglect

pretest to posttest measures (see figures below). For youth not reporting use at pretest, data regarding 30-day use at posttest revealed that:

- 82% remained nonusers of alcohol
- 83% remained nonusers of marijuana
- 78% remained nonusers of tobacco

BENEFITS

Teaches adolescents important resistance and social competency skills:
- Communication
- Decisionmaking
- Stress and anger management
- Problem solving
- Resisting peer pressure

HOW IT WORKS

A partnership is established between a prevention agency and residential facility. An individual with a master's degree in social work, counseling, or psychology, who is experienced in adolescent substance abuse prevention counseling, is recruited to work in the facility as a Student Assistance Counselor (SAC). The SAC provides the facility with a full range of substance abuse prevention and early intervention services that will help residents decrease their risk factors for substance abuse and increase their overall resiliency.

IMPLEMENTATION ESSENTIALS

RSAP requires the formation of a partnership between a prevention agency that will administer the program and a residential facility where it will operate. Specific staff involved in the partnership include:

- Residential Facility Senior Executive
- Executive Director/Project Director
- Student Assistance Counselor (SAC)
- Project Supervisor

These staff members must complete the following administrative steps to ensure successful program implementation:

- Define program goals and objectives
- Define target population
- Provide training and consultation for school staff
- Establish a school staff substance abuse task force
- Establish a school substance abuse task force
- Obtain technical assistance and training

A 75-page implementation manual, which includes resource material for professionals and worksheets for students, and a video are available. Onsite and offsite training of varying lengths, up to 5 days, is also available.

Start Taking Alcohol Risks Seriously (STARS) for Families

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PROVEN RESULTS*

STARS for Families participants are:

- 3.6 times less likely to plan to use alcohol in the next 6 months
- 4.8 times less likely to have drunk alcohol in the past 30 days
- 3.3 times less likely to be in an advanced stage of alcohol use
- 3 times less likely to drink alcohol during any length of time
- 2.3 times less likely to have drunk heavily during the past 30 days

*Results compared to control group.

Start Taking Alcohol Risks Seriously (STARS) for Families is a health promotion program for preventing alcohol use among at-risk middle and junior high school youth (11 to 15 years old). The goal of STARS for Families is to have all youth postpone alcohol use until adulthood. STARS for Families matches media-related, interpersonal, and environmental prevention strategies to each child's specific stages of alcohol initiation, stages of readiness for change, and specific risk and protective factors. This innovative program has been shown to result in avoidance of, or reductions in, alcohol use among participants.

PROGRAM BACKGROUND

STARS for Families was developed at the Center for Drug Prevention Research, University of North Florida, College of Health with grants from the National Institute on Alcohol Abuse and Alcoholism. STARS for Families is a health promotion program that uses health care providers and parent prevention materials to prevent alcohol use among at-risk youth. STARS for Families is founded on the Multi-Component Motivational Stages (McMOS) prevention model, which posits stages of habit initiation in health-damaging behavior, such as substance use, that parallel and exist in conjunction with the stages of change described in the Transtheoretical Model.

TARGET POPULATION

STARS for Families is designed for middle and junior high school youth and their families. The program has been tested and shown useful for 11- to 15-year-old youth in both urban and rural schools, and for youth attending physical exams for sports teams.

OUTCOMES

A longitudinal study of the STARS for Families program found that, relative to the controls, participants:

- Were less likely to be in more advanced stages of alcohol initiation, 3 months after completing the program
- Were less likely to have drunk alcohol in both the past 7 days and past 30 days, 3 months after program completion
- Were less likely to have drunk heavily during the past 30 days, 3 months after program completion

Target Areas

Protective Factors To Increase

Individual
- Problem-solving skills
- Communication and social skills
- Belief in society's values
- Motivation to pursue positive goals

Peer
- Association with peers who are involved in activities not involving alcohol

Family
- High parental expectations
- Clear and consistent expectations
- Parental involvement

Society
- Media literacy and resistance to pro-use messages

Risk Factors To Decrease

Individual
- Lack of self-control and peer-refusal skills
- Favorable attitudes toward alcohol use
- Low self-confidence in ability to refuse alcohol offers

Peer
- Association with peers who use alcohol
- Susceptibility to negative peer pressure

Family
- Family attitudes favorable toward alcohol use
- Ambiguous, lax, or inconsistent rules regarding alcohol use

- Were less likely to be planning to drink in the next 6 months, 1 year after the program ended
- Decreased their intention to drink in the future, 1 year after the program ended
- Had greater motivation to avoid alcohol use, 1 year after the program ended
- Experienced fewer total alcohol-use risk factors, 1 year after the program ended

Benefits
- Delays the onset of alcohol use among youth
- Reduces quantity and frequency of any alcohol use and heavy alcohol use among those already drinking
- Increases motivation to avoid alcohol use
- Reduces alcohol use risk factors and beliefs that support the use of alcohol
- Increases protective factors and resistance skills
- Increases parent-child communication about alcohol use prevention

HOW IT WORKS

STARS for Families consists of three primary strategies:
- Health Care Consultation—A nurse or other health care provider delivers a brief (20 minute) annual health consultation concerning how to avoid alcohol use.
- Key Facts Postcards—Ten Key Facts postcards are mailed to parents or guardians in sets of 1 or 2 per week for 5 to 10 weeks. The cards tell parents what they can say to their children to help them avoid alcohol.
- Family Take Home Lessons—Parents and guardians are provided with four weekly take home prevention activities they can complete with their children and return.

IMPLEMENTATION ESSENTIALS

Successful replication of STARS for Families involves:

- Recruiting participating youth of middle or junior high school age
- Training nurses or health care providers to administer the program
- Delivering and monitoring annual one-on-one nurse-youth consultations
- Delivering and monitoring implementation of Key Facts postcards
- Delivering and monitoring implementation of family take home lessons
- Conducting pre- and post-program outcome data collections to measure program effects

STARS for Families can be implemented anytime. A sample implementation timeline is provided in the STARS for Families Complete Manual, which also includes all intervention protocols, forms, process measures, program evaluation materials, and training materials. Intervention components are typically administered over the course of 1 to 3 years.

STARS for Families requires the participation of trained nurses or other health care providers and a program coordinator. These professionals will receive 1 to 2 days of training, and the program can be implemented immediately after training.

Strengthening Families Program (SFP)

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PROVEN RESULTS*

- Improves resilience, assets, and protective factors in children and parents
- Decreases risk factors in parents and children
- Decreases children's behavioral problems and conduct disorders
- Improves family cohesion, communication, and organization
- Decreases family conflict and stress

* Reductions in agggression and found conduct problems averaged 10 times larger than school-based,child-only prevention interventions.

The Strengthening Families Program (SFP) involves elementary school aged children (6 to 12 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by:

- Improving family relationships
- Improving parenting skills
- Increasing the youth's social and life skills

SFP offers incentives for attendance, good behavior in children, and homework completion to increase program recruitment and participation.

Program Background
SFP was originally developed by Dr. Karol Kumpfer and associates with a grant from the National Institute on Drug Abuse (NIDA) from 1982 to 1986. It developed out of multiple existing science-based prevention programs. A new 2001 version of SFP, available on CD-ROM, was modified based on practitioner feedback.

Target Population
SFP was originally developed and tested in 1983 with 6- to 12-year-old children of parents in substance abuse treatment. Since then, culturally-modified versions with new manuals have been evaluated and found effective for families with diverse backgrounds: African American, Asian/Pacific Islanders, Hispanic, American Indian, Canadian, and Australian. SFP is also now widely used with non-substance abusing parents in elementary schools, churches, housing communities, mental health centers, jails, homeless shelters, protective services agencies, and social and family services agencies.

Outcomes
Research, using randomized experimental designs and pre- and post-test data collection, has found consistent positive results for diverse families, and up to 5-year followup measures:

- Parent Training improves parenting skills and children's behaviors and decreases conduct disorders
- Children's Skills Training improves children's social competencies (i.e., communication, problem solving, peer resistance, and anger control)
- Family Skills Training improves family attachment, harmony, communication, and organization

Target Areas

Protective Factors To Increase

Individual
- Self-esteem
- Social and life skills
- Resistance to negative peer influences

Peer
- Pro-social friends
- Effective communication

Family
- Parenting efficacy
- Family organization
- Effective communication
- Parent-child attachment
- Parental mental health

School
- Grades
- School bonding

Risk Factors To Decrease

Individual
- Depression
- Conduct disorders
- Aggression
- Shyness and loneliness

Peer
- Substance-using friends
- Negative peer influence

School
- Tardiness
- Times absent

Family
- Family conflict
- Excessive punishment
- Child abuse and/or neglect
- Ineffective discipline
- Modeling of substance use by family members
- Differential acculturation

- The full SFP improves more risk and protective factors predictive of later problem behaviors than other studied interventions

BENEFITS
Immediate results include:

- Improvements in family environment and parenting skills
- Increased prosocial behaviors in children
- Decreased child depression and aggression
- Decreased substance use among parents and children

At 5-year followup

- 92% of families still used parenting skills, and 68% still held family meetings

HOW IT WORKS
The SFP curriculum is a 14-session behavioral skills training program of 2 hours each. Parents meet separately with two group leaders for an hour to learn to increase desired behaviors in children by increasing attention and rewards for positive behaviors. They also learn about clear communication, effective discipline, substance use, problem solving, and limit setting.

Booster sessions and ongoing family support groups for SFP graduates increase generalization and the use of skills learned.

IMPLEMENTATION ESSENTIALS
Successful replication of SFP requires:

- Implementation of all 14 Parent, Child, and Family Skills Training sessions using SFP manuals and meeting once or twice per week (Program manuals and other materials may be copied from a SFP CD-ROM.)
- An optimal family load of 4 to 14 families per group
- Committed and experienced staff, including a part-time site coordinator and four group leaders (working 5 hours per week) who receive 2 to 3 days of training from SFP master trainers (Warm, empathetic, genuine, and creative leaders are most effective.)
- Reunions or booster sessions of approximately 3 hours each every 6 months
- Two large training rooms equipped with flip charts and extra space and tables for meals and child care
- Family meals, transportation, and child-care should be provided (reduces barriers to attendance)

Students Managing Anger and Resolution Together (SMART) Team

Program Developer
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PROVEN RESULTS

- Greater self-knowledge of how specific behaviors can escalate a conflict situation
- Greater frequency of self-reported prosocial acts
- Increased intentions to use nonviolent strategies in future conflicts
- Increased self-reports of never getting into trouble at home (13% compared to 32%),at school (33% compared to 44%), and in the community (6% compared to 54%)

SMART Team is an eight-module, multimedia software program designed to teach violence prevention messages and methods to students in grades six through nine (11 to 15 years old). The program's content fits well with commonly used conflict-mediation curricula and other violence prevention strategies schools may implement. Operation is straightforward, so students can access the modules independently for information, skill-building practice, or to resolve a conflict. This independence eliminates the need for trained adult implementers.

PROGRAM BACKGROUND

SMART Team is one of a series of health, education, and prevention multimedia products developed since the early 1980s at the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. David H. Gustafson, Ph.D., Kris Bosworth, Ph.D., Robert Hawkins, Ph.D., and Betty Chewning, Ph.D., directed the development of the Body Awareness Resource Network (BARN) software that was the basis for SMART Team. The BARN software includes information and skill-building activities relating to six topics: 1) alcohol and other drugs, 2) body management, 3) human sexuality, 4) stress management, 5) smoking, and 6) HIV/AIDS. SMART Team originally was conceived as an additional module for the BARN system but later became a separate entity. The development of SMART Team began in 1993 with a contractual agreement with the Centers for Disease Control and Prevention, and was completed in 1996.

TARGET POPULATION

SMART Team is designed for use in middle and junior high school students, typically 11 to 15 years old. Evaluations conducted in a large middle school 10 miles from a major Midwestern city found the program motivating and effective for a broad range of students. In this school's population, which was socioeconomically and somewhat racially diverse (84 percent were Caucasian), evaluation results revealed no differences in use rates based on gender, ethnicity, or among students eligible for free or reduced-price lunches (which was used as a measure of socioeconomic status).

OUTCOMES

In the pilot study, SMART Team students demonstrated the following, relative to control groups:

- Correct responses on two of the four items increased significantly
- Significant increases in self-knowledge of how their behaviors can contribute to escalation of a conflict

Target Areas

Protective Factors To Increase

Individual
- Social and emotional competence
- Communication skills
- Responsiveness, empathy, and inclination toward prosocial behavior
- Self-discipline

Risk Factors To Decrease

Individual
- Inadequate life skills
- Lack of self-control and assertiveness
- Poor peer-refusal skills

Peer
- Susceptibility to negative peer pressure
- Strong external locus of control

- Significant increases in self-reported frequency of prosocial behavior and intention to use nonviolent strategies
- Self reports of never getting into trouble increased whether at home (13% to 32%), school (33% to 44%), or in the community (6% to 54%)
- Students reacted positively to the software: 89% found it easy to use, 91% agreed it was enjoyable to use, 68 % reported learning a lot, and 79% would recommend it to a friend
- Both males and females used the program and accessed a range of modules

In the formal evaluation, the intervention group, relative to no-treatment controls:

- Showed greater intentions to use nonviolent strategies ($p = .01$)
- Showed a reduction in beliefs supporting the use of violence ($p = .05$)

BENEFITS

SMART Team is designed to:

- Gain better understanding of others' perspectives
- Increased conflict resolution and anger management skills
- Decreased beliefs that support the use of violence
- Experience behavior modeling and decision-making in realistic contexts

HOW IT WORKS

SMART Team is designed so that the same basic content is present in every module, which allows modules to stand alone or be used in sequence. Thus students can acquire a basic set of declarative knowledge through any of the modules. The theoretical underpinnings of the instructional design are twofold:

- A skill acquisition model that postulates five stages of learning a new skill, from novice to expert, with learners having different needs at each stage.
- Social learning theory that contributes an understanding of how children observe the verbal and nonverbal behavior of role models.

IMPLEMENTATION ESSENTIALS

The SMART Team software has been used primarily in schools, where it was loaded on computers located in classrooms, computer labs, and counselors' offices. However, SMART Team may be used in other settings such as community agencies. The sole constraint on where it can be used is the need for the necessary computer hardware. SMART Team software is designed to operate on a Macintosh computer with a 68020 CPU or greater, 1.5 MB of RAM, 7.5 MB of hard drive space, and a System 7.0 or newer CD-ROM. Less than a half-hour is required to load the program prior to initial use. Thereafter, the program has proved simple enough to be accessed independently by students with rudimentary computer skills. In fact, the program is so easy to use, no requests for instructor or teacher training have ever been made. Teachers may wish to conduct a follow-up discussion to ascertain students' reactions and reinforce the content of the modules, but direct teaching is optional.

2002 Conference Edition

FAXBACK FEEDBACK

This Handbook is intended for use
by prevention practitioners and professionals at the State and local levels.

Please rate your satisfaction with following dimensions of the Handbook

CONTENT	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1.Rele vance of the inf ormation					
2.Accuracy of the information					
3. Timeliness of the inf ormation					

FORMAT	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1. Overall Presentation					
2. Readability					
3. Organization					

UTILITY	Very Useless	Somewhat Useless	Neutral	Somewhat Useful	Very Useful
1. This product will be useful this time next y ear.					
2.This product is useful to the selected audience .					
3. This product is useful given the expected e xpense .					

COMMENTS:

SUGGESTED TOPICS FOR SIMILAR PRODUCT DEVELOPMENT:

AFFILIATION: POSITION:

Please fax your feedback forms to the National Center for the Advancement of Prevention at (301) 984-6095.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

How to obtain this document:

This document can be obtained online at Internet sites sponsored by the Federal Center for Substance Abuse Prevention (CSAP):

CSAP Prevention Decision Support System (DSS) Web site:
www.preventiondss.org

CSAP Model Programs Web site:
www.modelprograms.samhsa.gov/

CSAP Prevention Pathways Web site:
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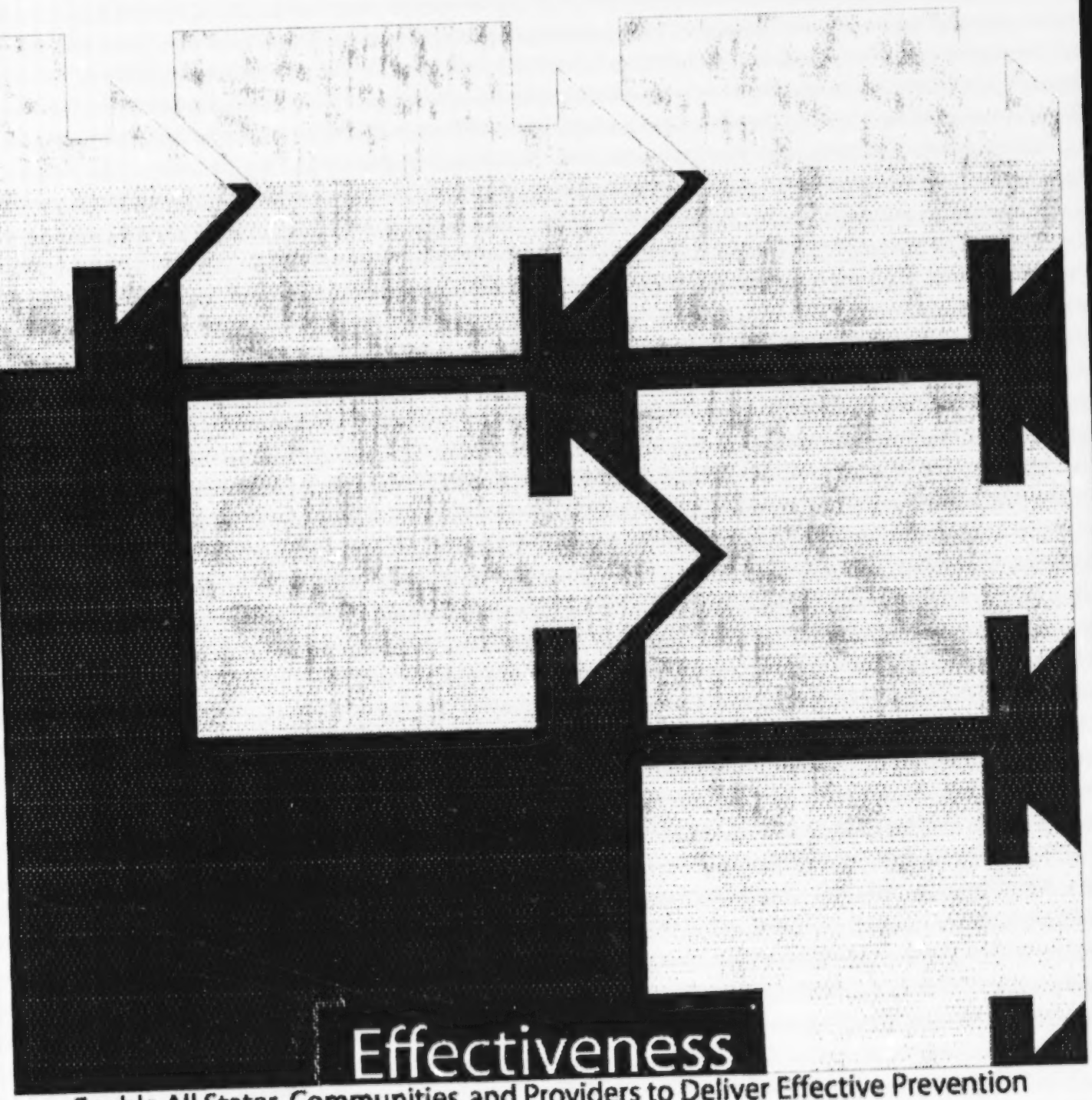

Effectiveness

Enable All States, Communities, and Providers to Deliver Effective Prevention

CSAP Center for Substance Abuse Prevention

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